

FOR STATE
HEALTH DEPT.

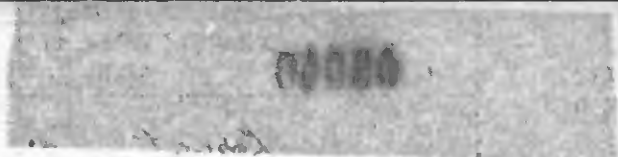
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "PM-3". Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05042

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Robert L. ABRISCH					Month 4 Day 10 Year 1968					A M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
M	W	9/24/1906		67 YRS	MONTHS DAYS		HOURS MIN		Month 4 Day 10 Year 1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR		
Md.		USA				Anne Arundel - Co.		A M		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Glen Burnie		DORR-NO. 46 ANKUNDEL -		Gas Att. Retired		American				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MD		HARCO		Pasadena				Chester Beach		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
First Middle Last William F, Abrisch				First Middle Last Mattie Forwood						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
Yes				WV2		217.09.8765 Evelyn V. Abrisch		same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>degenerative CVS</u>										<u>minutes</u>
DUE TO, OR AS A CONSEQUENCE OF										
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
				19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>[Signature]</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED		
EXAMINER'S NAME (Type) <u>E. Linhart St.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				<u>4-10-68</u>		
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				<u>P.P. Ed.</u>		
				ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4/15/68		Baltimore National		Baltimore Md.				
24. FUNERAL DIRECTOR <u>J.T. Stansbury</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
6411 Windsor Mill Rd.						DATE <u>Apr 15 1968</u>		<u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. TIME		
Doyal		A.	Alther - SR.		April 12, 1968		2:30 PM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		8. YRS.		
Male	White		1-10-10		58				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U.S.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie, Md.		NORTH ARUNDEL		Retired		Beth Steel Co			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Anne Arundel		Glen Burnie				711 Berry Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Lost		First Middle Lost							
(unknown)		Alther		(Unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT					
Yes		1929-1938		579-16-3304 Doyal A. Alther - Jr. Balto. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i>								<i>Hours</i>	
4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								<i>Days</i>	
(b) <i>arteriosclerotic heart disease</i>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>19</i> , 19 <i>66</i> , to <i>4-12</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>March 19</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<i>Hilary T. O'Herlihy</i>				<input checked="" type="checkbox"/>				<i>4-12-68</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Dr. Hilary T. O'Herlihy		Suite 208		325 Hospital Dr., Glen Burnie, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/15/68		Cedar Hill Cemetery		Brooklyn Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<i>Robert P. Ware</i>				DATE		<i>Charles J. J...</i>			
Singleton Funeral Home/Glen Burnie, Md.				APR 15 1968					

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Carte de l'Asie

Carte de l'Asie
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2-12-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First COLENA		Middle I		Last ARMOUR		2a. DATE OF DEATH 4 Month 27 Day 68 Year		2b. HOUR 4:30 PM	
3. SEX f		4. RACE C		5. DATE OF BIRTH 4/15/1886		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.					
10. CITY OR TOWN OF DEATH CROWNSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CROWNSVILLE STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased admission) STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1218 N. CHESTER STR.			
14. FATHER'S NAME First SCOTT		Middle BRYANT		Last DAVSH		15. MOTHER'S MAIDEN NAME First DAVSH		Middle BRYANT		Last BRYANT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. 2		17. INFORMANT HOSPITAL RECORDS		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445.0 GANGRENE OF FOOT, SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4501 NONE											
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 4/26/68, 19__, to 4/27/68, 19__, that (I) (we) last saw the deceased alive on 4/26/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. BENEDICT M.D.		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/27/68					
22d. PHYSICIAN'S NAME (Type) L. BENEDICT M.D.		22e. ADDRESS Crownsville State Hospital									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 1/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION (City or Town) A. D. County Md		(County)		(State)	
24. FUNERAL DIRECTOR Barbara T. Ellickson		ADDRESS 11299 Cedar St		25a. REC'D BY REGISTRAR MAY 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

14080

WYOMING

14080

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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
CARL E. BAASE					APRIL 17 1968		4:35 PM	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years lost birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White	1-15-99			69 YRS.	MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED- WIDOWED		NEVER MARRIED DIVORCED	9. COUNTY OF DEATH			
Germany	U.S.A.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Severn, Md	367 Quarterfield Rd		Carpenter (Ret)		Roescher Corp			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
Md	A.A.G.	Severn	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	367 Quarterfield Rd				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
(Unknown)				Baase	(Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		None		913-10-7669A MRS Elizabeth C. Baase (Wife)		Same as 412		
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis with 410.9								
DUE TO, OR AS A CONSEQUENCE OF myocardial infarction								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1								
(b) Atherosclerotic cardiovascular disease.								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
Shakeria mellitus, mild.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
		HOUR A.M. Month Day Year						
		P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.				
22a. I certify that (I) (this hospital) attended the deceased from January 19 68, to April 19 68, that (I) (we) lost saw the deceased alive on April 19 68, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
B. A. de GURZMAN								4/17/68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
B. A. de GURZMAN		335 HOSPITAL DR., GLEN BURNIE						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		April 20 1968		Glen Haven Mausoleum		Glen Burnie, Md		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
E. P. Flannery		4101 Sigshester Funeral Home, Glen Burnie		APR 19 1968		J. J. J. J.		

2000

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-13. Page 5 may be retained for your files.

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05044
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item#8, Film#G400 5/1 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) ROBERT S. BAKER			2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year April 15, 1968			2b. HOUR 8:45 M			
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH	6. AGE (In years last birthday) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month April Day 15 , Year 1968			2d. HOUR 8:45 A
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md			
10. CITY OR TOWN OF DEATH Jessups			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Maryland House of Correction			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2557 W. Lafayette Ave.
14. FATHER'S NAME Lawrence Baker			15. MOTHER'S MAIDEN NAME Birdie			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			
16b. SOCIAL SECURITY NO.			17. INFORMANT William Baker			ADDRESS 2557 W. LaFayette Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Overdose of Narcotics 304.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 323x									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Ronald N. Kornblum			M.D. Ronald N. Kornblum, M.D.			22b. DATE SIGNED 4-15-68			
EXAMINER'S NAME (Type)			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/19/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Charles A. Rice				ADDRESS 661 W. Barre St.		25a. REC'D BY REGISTRAR MAY 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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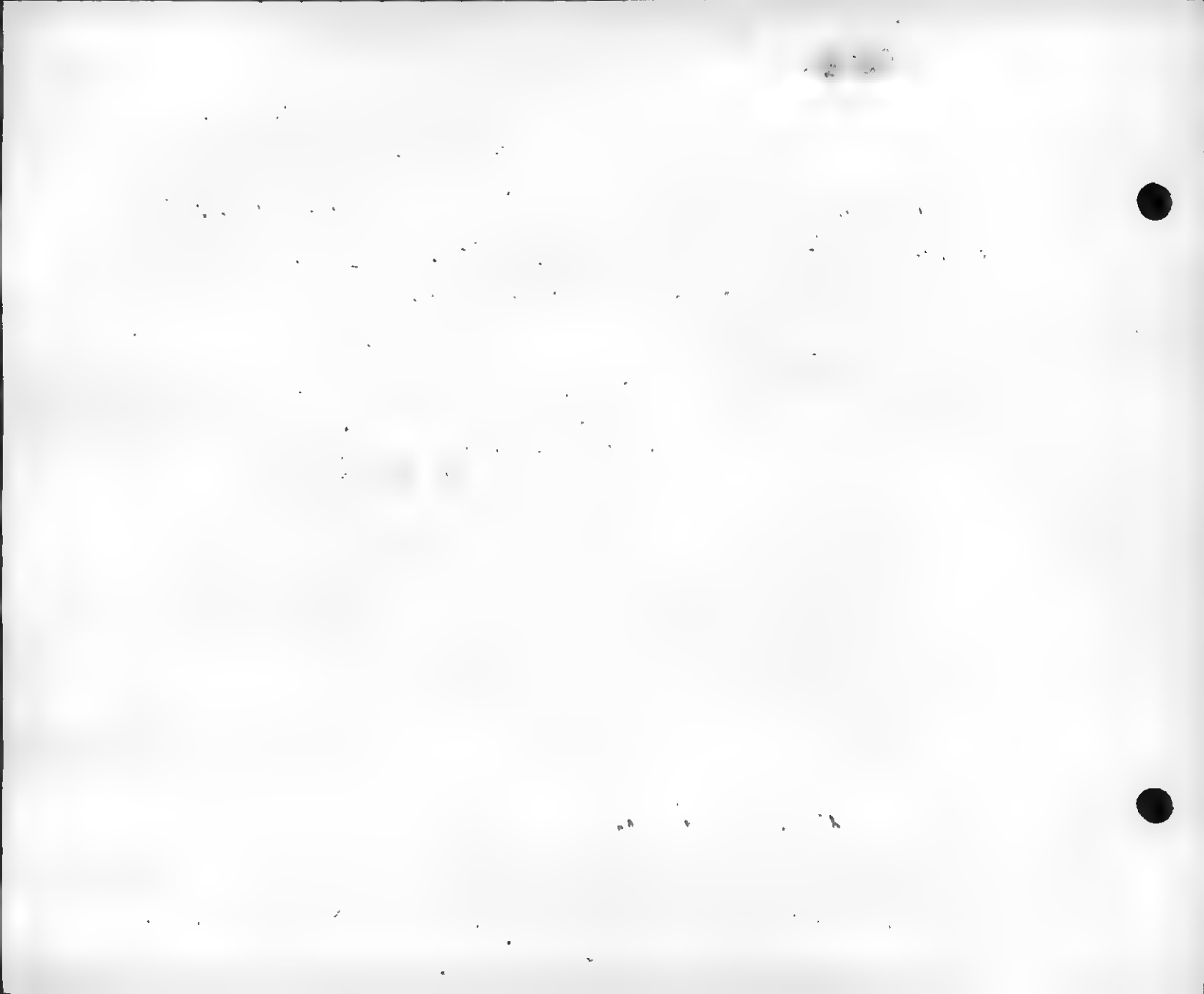
Items 18-22a Film 400
2-10-68 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05045

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) SHIRLEY E. BAKER			2a. DATE OF DEATH Month APRIL Day 26 Year 1968			2b. HOUR M	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH SEPT. 8-1934		6 AGE (In years lost birthday) 33 YRS	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH ANNE ARUNDEL Md.	
10 CITY OR TOWN OF DEATH ANNAPOLIS		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ANNE ARUNDEL GEN. CLER		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CLER		12b K IND OF BUSINESS OR INDUSTRY STATE	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b COUNTY QUEEN ANNE		13c CITY OR TOWN STEVENSVILLE		13d INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER XX		14 FATHER'S NAME First CARL Middle EATON Last EATON		15 MOTHER'S MAIDEN NAME First JULIA Middle CLARK Last CLARK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b SOCIAL SECURITY NO 214-52-8090		17 INFORMANT W. RAYMOND BAKER Address STEVENSVILLE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema REMEDIATION / RADIATION / CHEMOTHERAPY DUE TO, OR AS A CONSEQUENCE OF Aspiration of vomitus (gastric mucous) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Aspiration of vomitus (gastric mucous) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5221							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE William Branch MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE APRIL 29		23c. NAME OF CEMETERY OR CREMATORY STEVENSVILLE		23d. LOCATION (City or Town) (County) (State) STEVENSVILLE MD.	
24. FUNERAL DIRECTOR Edgar L. Lane		ADDRESS CHURCH HILL MD		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE MAY 01 1968 J. Charles Judge	



CERTIFICATE OF DEATH

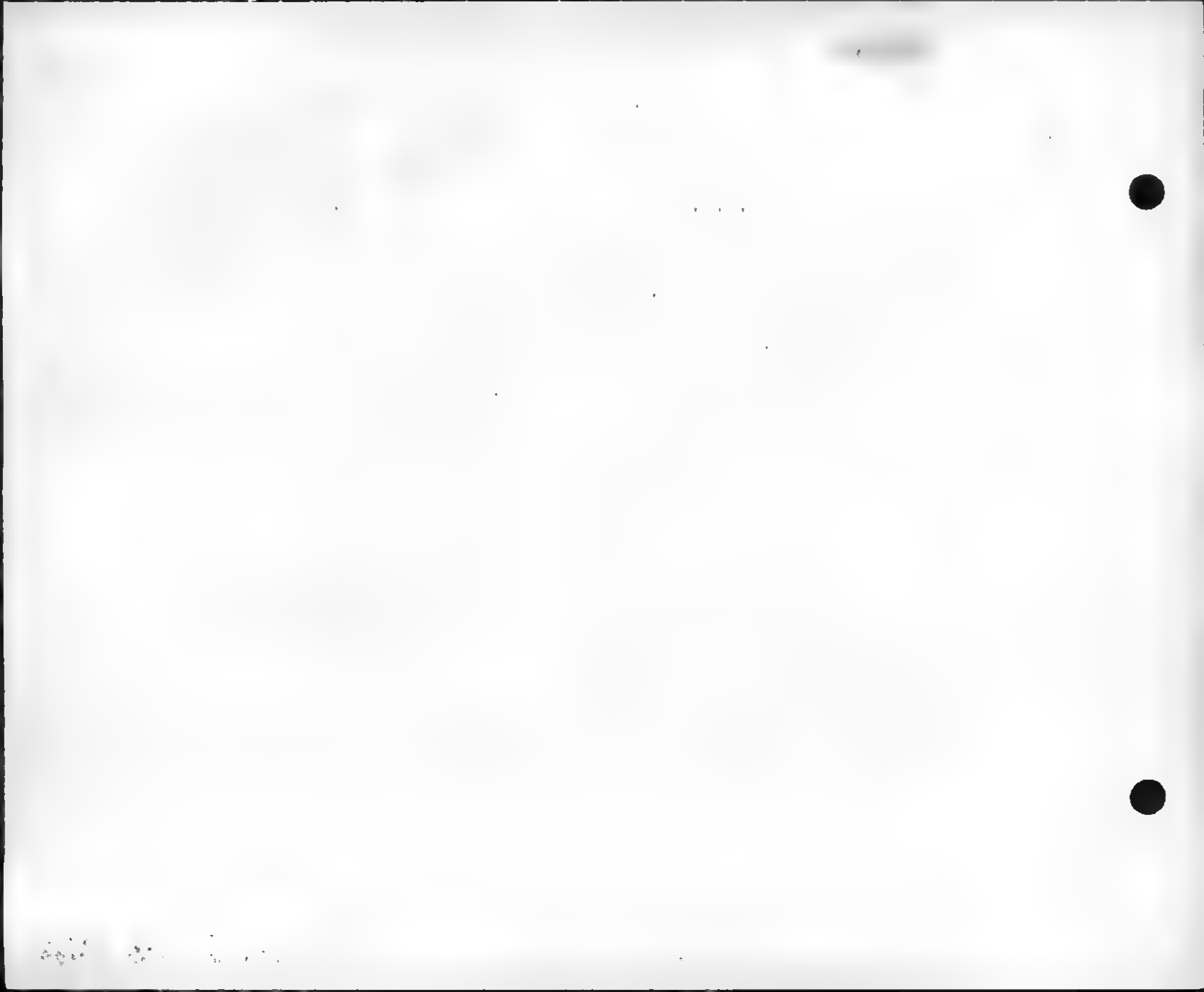
05046

028

1. DECEASED NAME (Type or print) DAVID		First DAVID	Middle U..	Last BARBOUR	2a. DATE OF DEATH XXXX Month 4 Day 8 Year 68		2b. HOUR 12:08
3 SEX Male		4 RACE White		5. DATE OF BIRTH 11-9-15		6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A. Md.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Service Sta. Operator		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY L.M. 15? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
14. FATHER'S NAME First David D. Middle Barbour Last Barbour		15. MOTHER'S MAIDEN NAME First Mattie Middle Stroup Last Stroup		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown			
16b. SOCIAL SECURITY NO 215-03-0477		17. INFORMANT Address Mrs. Dorothy V. Barbour, Furnace Dr. & 6th Ave.					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Terminal Metastatic Carcinoma 11/24 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Metastatic Carcinoma of Sculp & Brain DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 129							
19a. DATE OF OPERATION 1/25/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Excision of Carcinoma of Sculp		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on April 8 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Paul J. Chang		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/9/68	
22d. PHYSICIAN'S NAME (Type) Dr. Paul J. Chang		22e. ADDRESS 801 Cain Hwy SE, Glen Burnie, Md					
23a. BURIAL, CREMATATION, REMOVAL (Specify) BURIAL		23b. DATE 4-12-1968		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Hubbard Funeral Home		ADDRESS Wilkins Ave		25a. REC'D BY REGISTRAR APR 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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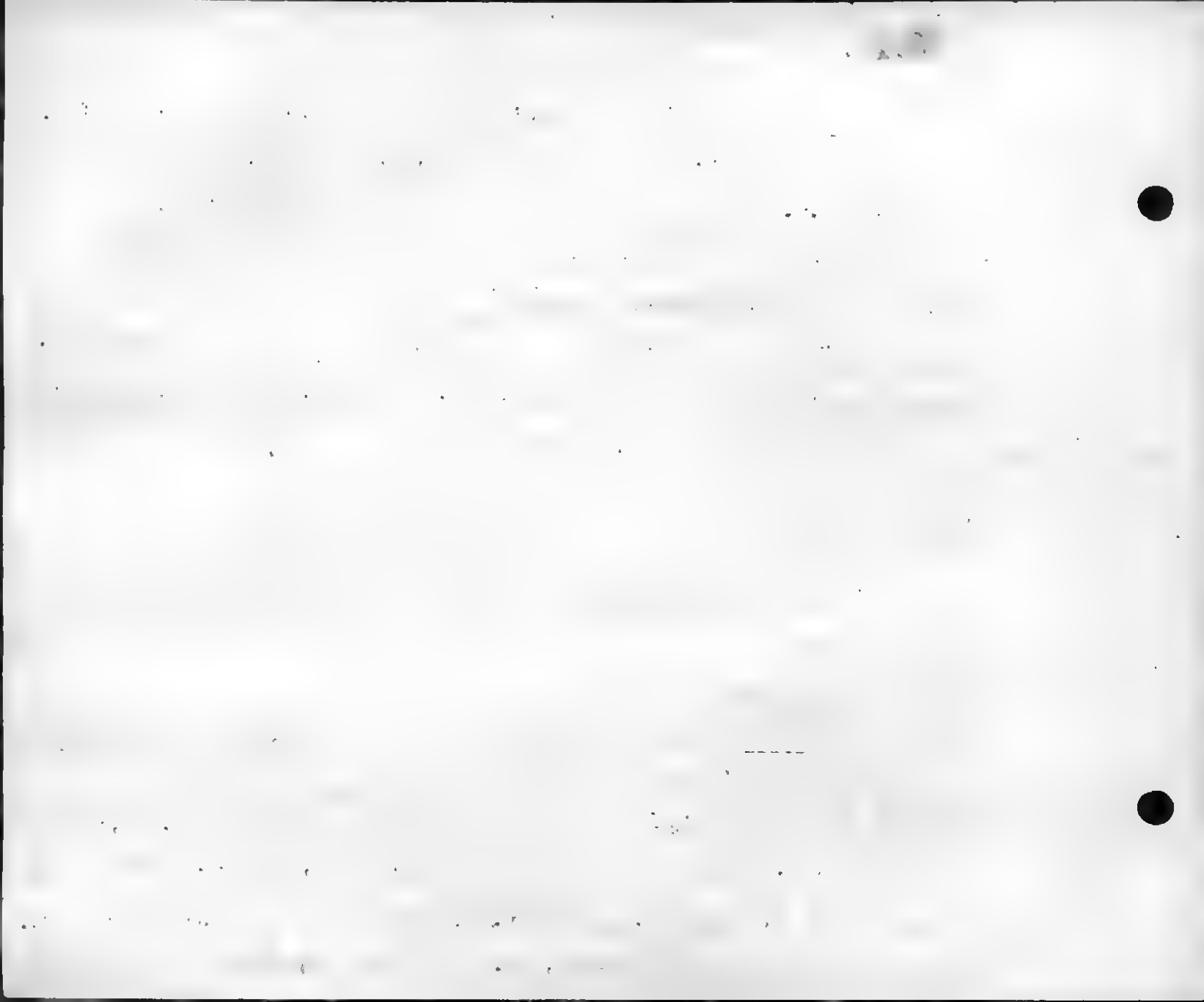
VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05047

05049

1 DECEASED-NAME (Type or print) First Middle Last DOROTHY LOUISE BEACH			2a DATE OF DEATH Month Day Year April 30 1968		2b HOUR 2 A. M.
3 SEX Female	4 RACE Cau.	5 DATE OF BIRTH July 13, 1912		6 AGE (In years lost birthday) 55 YRS.	7 UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Anne Arundel Co. Md.					
10 CITY OR TOWN OF DEATH Tracys Landing		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ---		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
12b KIND OF BUSINESS OR INDUSTRY Domestic					
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland		13b COUNTY Anne Arundel		13c CITY OR TOWN Tracys	
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 			
14. FATHER'S NAME First Middle Last Albert Niess			15. MOTHER'S MAIDEN NAME First Middle Last Louise Richardson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 		17 INFORMANT Address Arthur E. Beach Tracys Landing, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma (Bone) DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 					
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC. 		21f. LOCATION Street or R.F.D. No City or Town County State 	
22a. I certify that (I) (this hospital) attended the deceased from 11/10 , 19 67 , to 4/30 , 19 68 , that (I) (we) last saw the deceased alive on 4/8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>G. J. Weems</i>				22c. DATE SIGNED Apr. 30, 1968	
22d. PHYSICIAN'S NAME (Type) G. J. Weems				22e. ADDRESS Huntingtown, Maryland 20639	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 2, 1968		23c. NAME OF CEMETERY OR CREMATORY St. James Chr. Cemetery	
23d. LOCATION (City or Town) (County) (State) Lothian Anne Arundel Md.					
24. FUNERAL DIRECTOR <i>W. Harry Hutchins</i>		ADDRESS Owings, Md.		25a. REC'D BY REGISTRAR DATE MAY 6 1968	
				25b. REGISTRAR'S SIGNATURE <i>Charles J. Jager</i>	



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VR A-100-1
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05048

CERTIFICATE OF DEATH

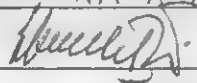

1. DECEASED NAME (Type or print) John Fredrick Bendermeyer			2a. DATE OF DEATH Apr. Month 2 Day 68 Year			2b. HOUR P 8:55 M			
3 SEX Male		4. RACE Cauc.		5. DATE OF BIRTH Feb. 1, 1910		6 AGE (In years last birthday) 58 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md			
10 CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) D.O.A. N. Arundel Hosp.		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Real Estate Salesman		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE Md.		13b COUNTY Balto.		13c CTY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 603 Crosby Rd.	
14 FATHER'S NAME First Middle Last Edward Bendermeyer				15 MOTHER'S MAIDEN NAME First Middle Last Daisy Bendermeyer					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes WW11		16b SOCIAL SECURITY NO 212-20-2497		17 INFORMANT 603 Crosby Rd Mrs. Dorothy Bendermeyer, Balto., Md. 212					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MYOCARDIAL INFARCTION 410.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH INSTANT 16 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 410.0									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from February, 1952 , to April 2, 1968 , that (I) (we) last saw the deceased alive on MARCH 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Melvin N. Borden MD DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/2/68			
22d. PHYSICIAN'S NAME (Type) Dr. Melvin Borden				22e. ADDRESS 5000 Balto. Wash. Natl. Pike, Baltimore Md.					
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-5-68		23c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		23d LOCATION (City or Town) Balto., Md.		(County) (State)	
24 FUNERAL DIRECTOR 4101 Edmondsann Ave Witzke Funeral Directors, Balto., Md. 21229				25a REC'D BY REGISTRAR APR 5 - 1968		25b REGISTRAR'S SIGNATURE Charles Judge			

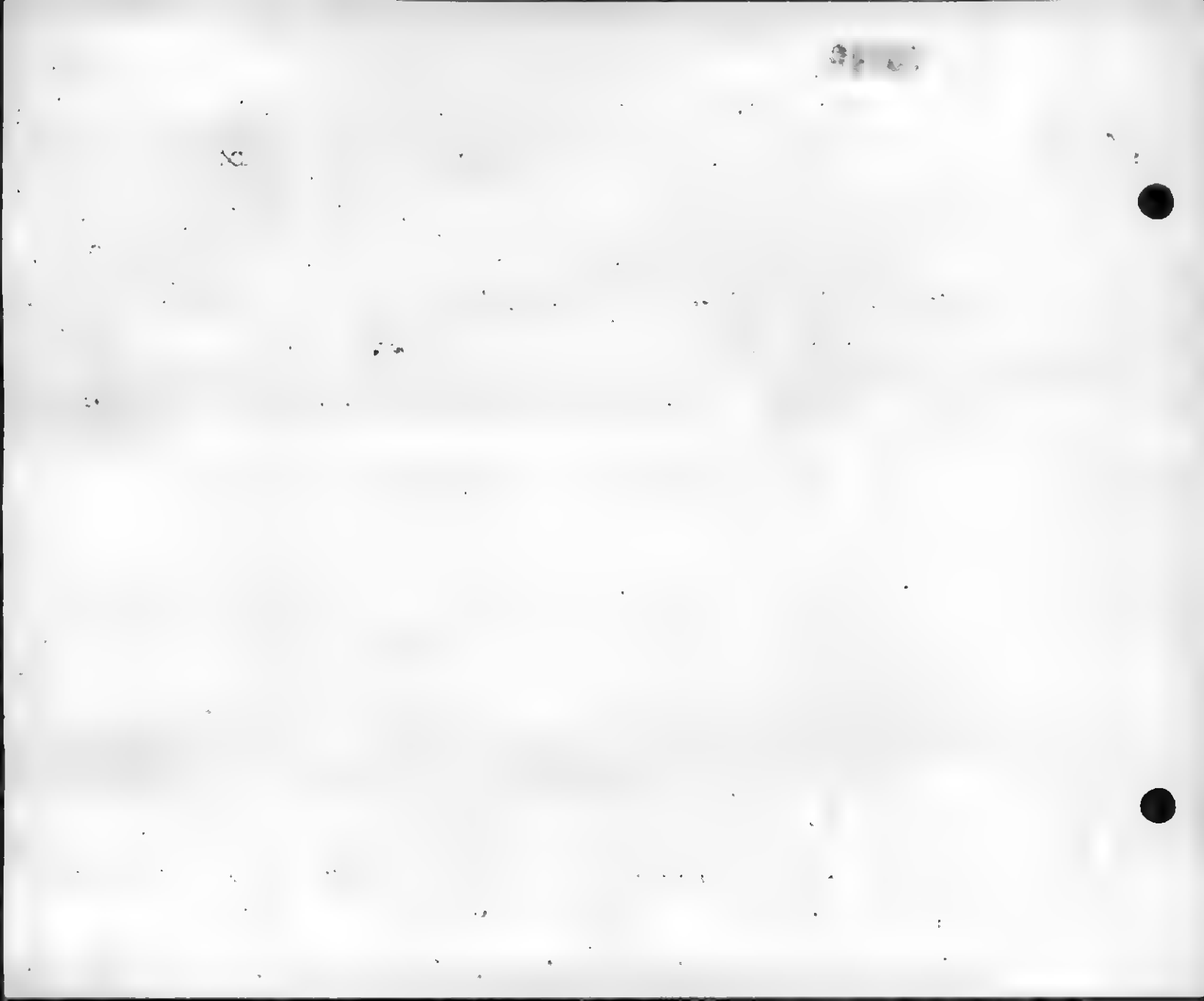


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Helen Gertrude Bennett			2a. DATE OF DEATH Month Day Year 4 25 68		2b. HOUR 10:28a
3 SEX Female	4 RACE Negro	5 DATE OF BIRTH 11/9/83		6 AGE (In years last birthday) 84	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) unknown	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Anne Arundel Md		
10 CITY OR TOWN OF DEATH Crownsville		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Crownsville State Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic	
12b KIND OF BUSINESS OR INDUSTRY Pvt/ Family					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before age 15) Catonsville Md.	13b COUNTY Balto. ✓	13c CITY OR TOWN Catonsville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 121 Winters Lane	
14 FATHER'S NAME First Middle Last William O. Powell			15 MOTHER'S MAIDEN NAME First Middle Last Mary Jenson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, Crownsville State Hosp. Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASHD</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4200</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus; uremia; dehydration.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from <u>9/27/</u> 19 <u>59</u> , to <u>4</u> <u>25</u> 19 <u>68</u> , that (4) (we) lost saw the deceased alive on <u>4</u> <u>25</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b SIGNATURE 		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 4/25/68	
22d PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22e ADDRESS Crownsville State Hospital, Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/29/68	23c. NAME OF CEMETERY OR CREMATORY Western Star Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore Co. Maryland	
24. FUNERAL DIRECTOR Herbert E. Nutter		ADDRESS 205 W. North Ave.		25a. RECEIVED BY REGISTRAR MAY 6 1968 DATE	
				25b. REGISTRAR'S SIGNATURE 	



FOR STATE
HEALTH DEPT

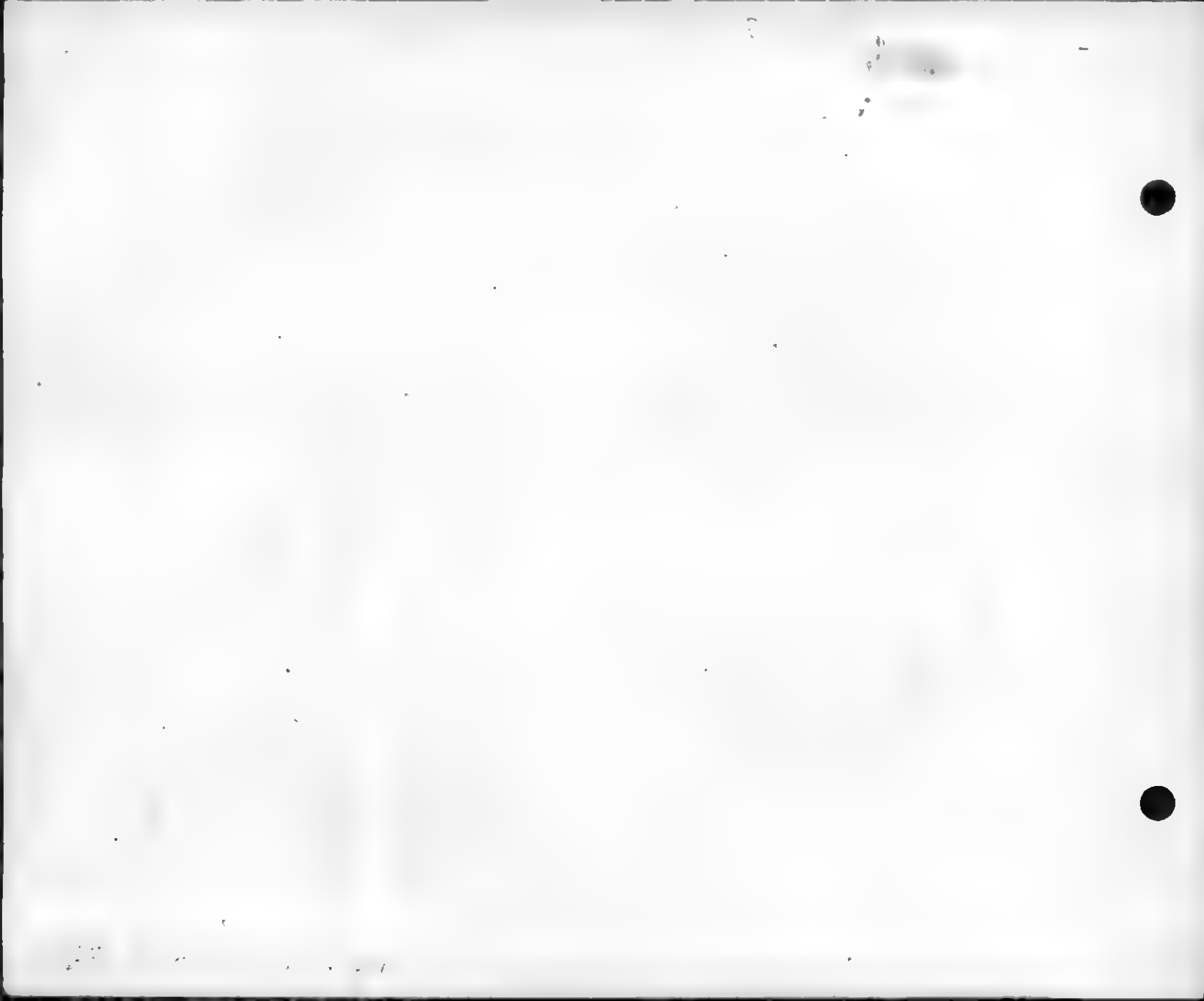
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <i>Russell E. Bennett</i>		First Middle Last		2a. DATE KNOWN OF ESTIMATED DEATH <input checked="" type="checkbox"/> Month <i>4</i> Day <i>15</i> Year <i>68</i>				2b. HOUR <i>A</i> M			
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>3-18-58</i>	6. AGE (In years last birthday) <i>10</i> YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month <i>4</i> Day <i>15</i> Year <i>68</i>		2d. HOUR <i>A</i> M	
7a. BIRTHPLACE (State or foreign country) <i>Bethesda, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>P. A. CO.</i>				Md	
10. CITY OR TOWN OF DEATH <i>Annapolis -</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>800-Ann Arbor Rd. Gen</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE <i>MD</i>		13b. COUNTY <i>AA CO</i>		13c. CITY OR TOWN <i>Edgewater</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>PL 4 - Box 612</i>			
14. FATHER'S NAME <i>Russell W. Bennett</i>				15. MOTHER'S M A D E N NAME <i>Mary Louise Norris</i>				17. INFORMANT <i>Father</i> <i>Russell W. Bennett</i> ADDRESS <i>Same as Item 13.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO <i>None</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: <i>Tracheo Cerebral Hemorrhage</i> IMMEDIATE CAUSE (a) <i>Tracheo Cerebral Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Tracheo Cerebral Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Tracheo Cerebral Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Tracheo Cerebral Hemorrhage</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <i>NO P.M. 4-15-68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Struck by auto</i>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>		21f. LOCATION Street or R.F.D. No <i>nearby Creek Rd</i>		City or Town <i>AA CO</i>		County <i>MD</i>		State	
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>E. Linhart</i> EXAMINER'S NAME (Type) <i>E. Linhart</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <i>4-15-68</i> <i>AA CO</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-18-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>				
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>APR 22 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



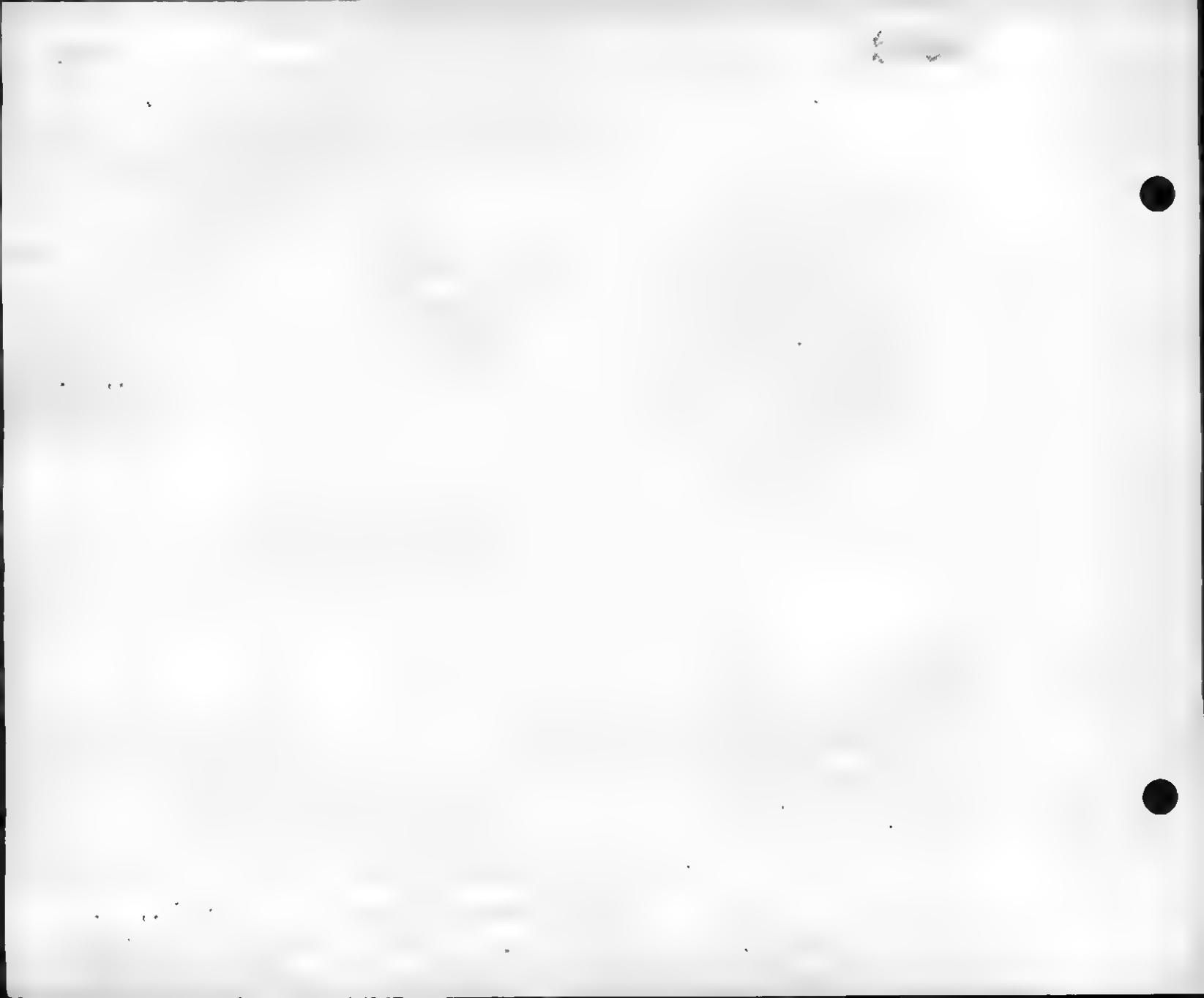
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1002, Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05052

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <i>William E Boulden</i>			2a. DATE KNOWN OF ESTI DEATH: MATED <input checked="" type="checkbox"/> 4 30 1968 P M			2b. HOUR		
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>11-22-34</i>	6. AGE (in years last birthday) <i>33</i> YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	8. UNDER 24 HRS MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month <i>4</i> Day <i>30</i> Year <i>1968</i> P M		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>ANNE ARUNDEL - CO</i> Md.		
10. CITY OR TOWN OF DEATH <i>glen burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>NORTH ARUNDEL HOSP</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Service Station</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Essex</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>1652 Poles Road</i>
14. FATHER'S NAME First Middle Last <i>Edward W. Boulden</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Irene Wilson</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) <i>219 30 6074</i>		17. INFORMANT ADDRESS <i>Irene Kacala 1652 Poles Road Balto., Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Injury to Chest</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>8.1.1</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>40 MIN'S</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>11.54</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. <i>P.M.</i> <i>4/30</i> 19 <i>68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Auto accident</i>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>		21f. LOCATION Street or R.F.D. No. <i>RR 175</i>		City or Town <i>A.N.C.O</i>		County <i>MD</i>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>E. Linhardt</i> EXAMINER'S NAME (Type) <i>E. Linhardt</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>ARCO</i>		22b. DATE SIGNED <i>4/30/68</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/4/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holly Hill Memorial Gardens</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Co., Md.</i>		
24. FUNERAL DIRECTOR <i>Prudcinski Funeral Home</i>				ADDRESS <i>1407 Eastern Ave.</i>		25a. REC'D BY REGISTRAR <i>MAY 3 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

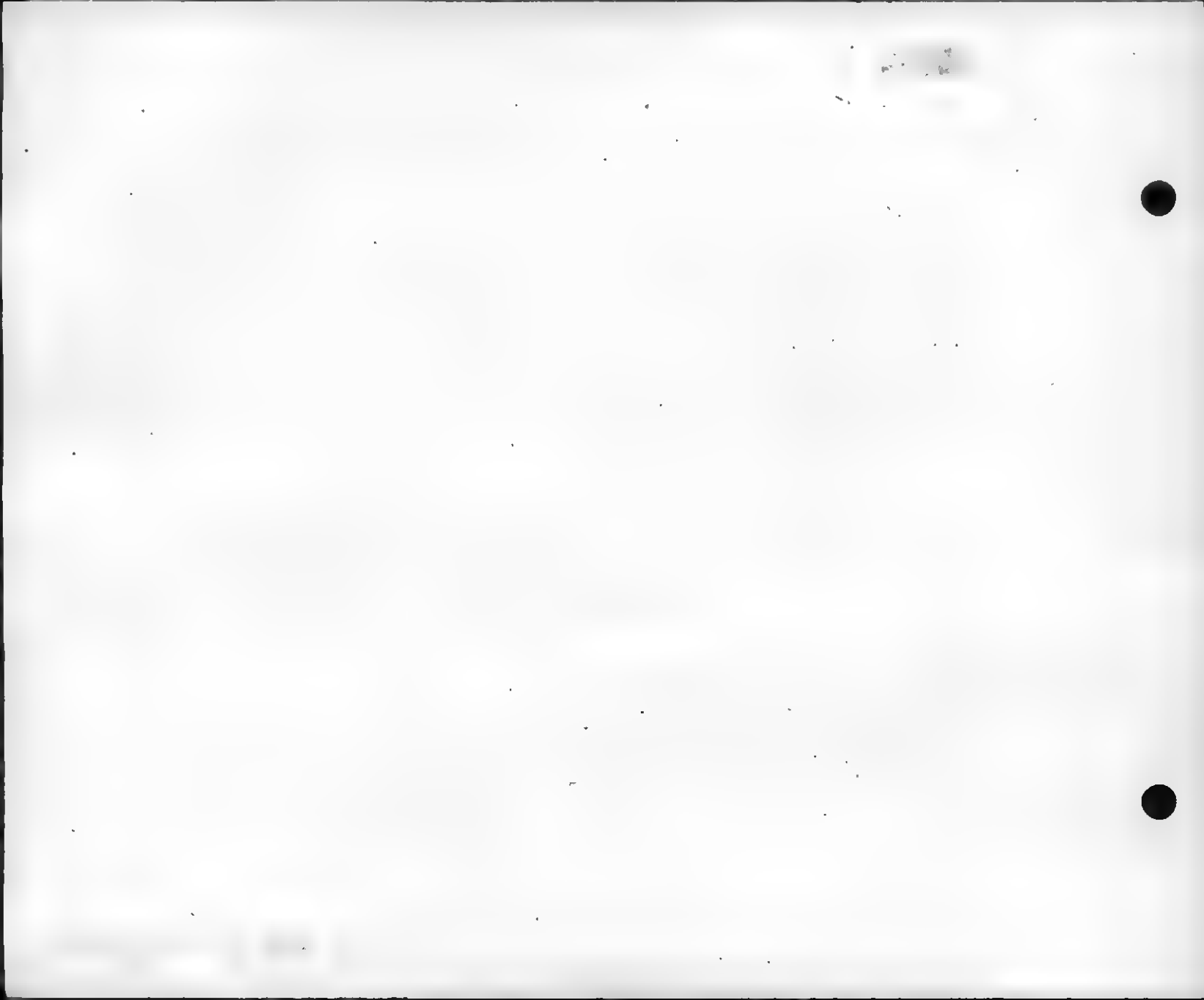
5054

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print) <i>Osear</i> First <i>Brown</i> Middle Last		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 4 17 68 Month Day Year		2b HOUR <i>P</i>
3 SEX <i>M</i>	4 RACE <i>N</i>	5 DATE OF BIRTH <i>7/22/28</i>	6 AGE (in years last birthday) <i>42</i> YRS	7 UNDER YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) <i>South Carolina U.S.A.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 COUNTY OF DEATH <i>A.A. Co</i> Md.
10 CITY OR TOWN OF DEATH <i>Annapolis</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A.A. County Retired</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>
13a USUAL RESIDENCE (Where deceased lived, if not institution, residence before admission) STATE <i>Md.</i>		13b COUNTY <i>A.A.</i>	13c CITY OR TOWN <i>Annapolis</i>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14 FATHER'S NAME <i>William</i> First <i>Monroe</i> Middle Last		15 MOTHER'S MAIDEN NAME <i>Kaisley Ballard</i> First Middle Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO <i>23940 24720-5698</i>		17 INFORMANT <i>Margaret Brown</i> ADDRESS <i>23 Bloomburg Square</i>
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drowning</i> <i>401X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Short</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>175X</i>				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <i>4-17 1968</i> HOUR <i>P.M.</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Jumped from Bay Bridge</i>
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Bay Bridge</i>		21f LOCATION Street or R.F.D. No <i>APCO MD</i> City or Town <i>APCO</i> County <i>MD</i> State <i>MD</i>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>E. Linhardt</i> EXAMINER'S NAME (Type) <i>E. Linhardt</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>4-19-68</i>
ADDRESS (Street, city, town, or county) <i>APCO</i>		23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b DATE <i>4-24-1968</i> 23c NAME OF CEMETERY OR CREMATORY <i>Balto National</i> 23d LOCATION (City or town) (County) (State) <i>Baltimore Md.</i>		
24 FUNERAL DIRECTOR <i>William Reese</i> ADDRESS <i>Annapolis Md.</i>		25a REC'D BY REGISTRAR <i>APR 22 1968</i> 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05053

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05055

1 DECEASED NAME (Type or print) William Roland BROWN			2a. DATE OF DEATH Month April Day 28 Year 1968			2b. HOUR A.M. 4:40	
3. SEX M		4. RACE W		5. DATE OF BIRTH 3-23-1917		6. AGE (In years lost birthday) 51 YRS.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dead on arrival Anne Arundel Gen. Hosp.		12a. USUA. OCCUPATION (Kind of work done during most of work no life, even if retired.) CIVIL SERVICE		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1027 Forest Hill Dr.		14. FATHER'S NAME First JAMES A. Middle BROWN Last ANNIE E.		15. MOTHER'S MAIDEN NAME First MULLEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not, or unknown YES (If yes give dates of service) WW II		16b. SOCIAL SECURITY NO.		17. INFORMANT ANCE L. BROWN #13		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/20 , 19 68 , to 4/28 , 19 68 , that (I) (we) last saw the deceased alive on 4/24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard I. Hochman, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/30/68	
22d. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22e. ADDRESS 16 Murray Ave., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-2-68		23c. NAME OF CEMETERY OR CREMATORY HILLCREST		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. MD.	
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE John Charles Judge			



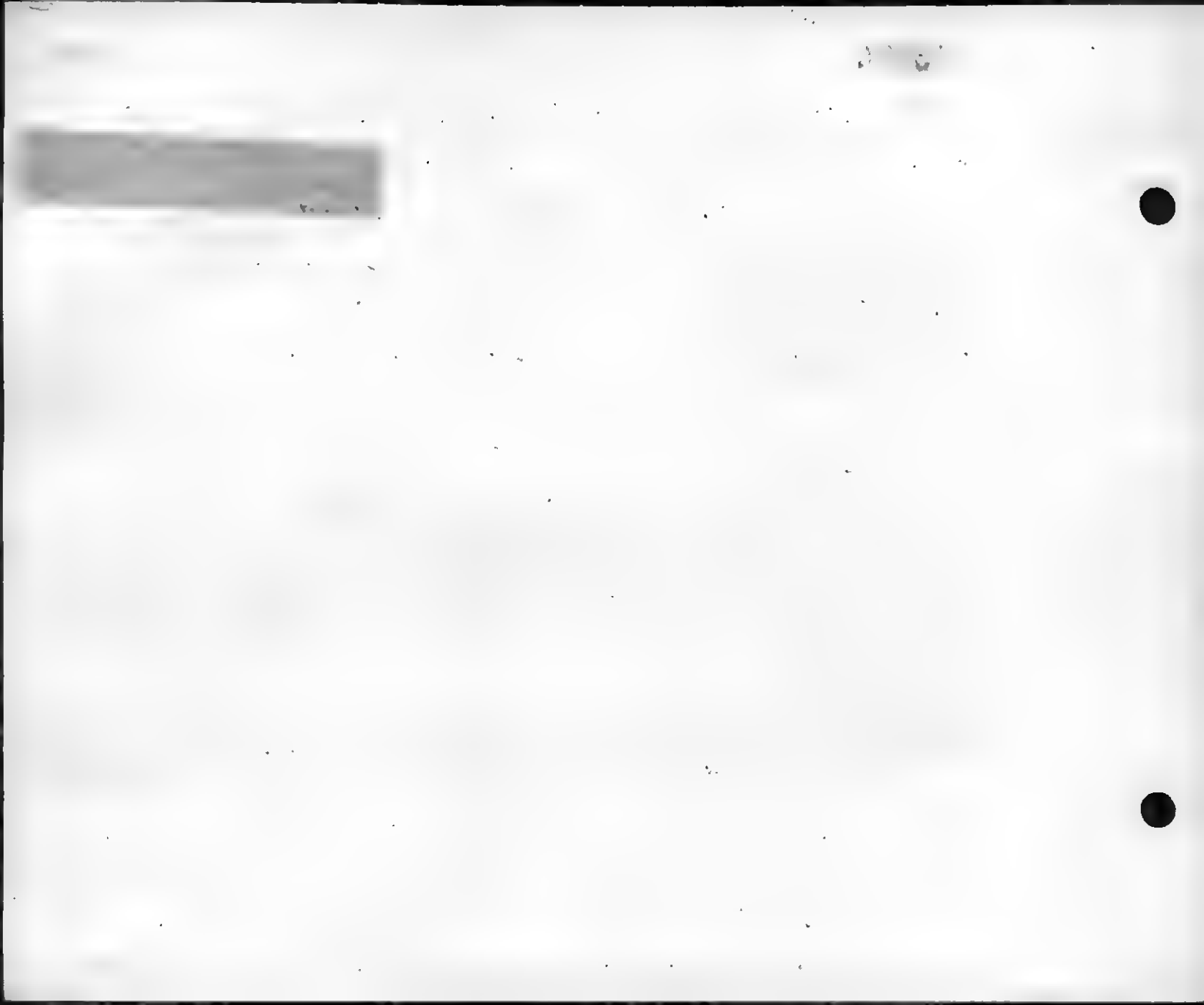
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

301-15 (4)
301-15 REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last ANNA CRISTIANNA DRUNDAGE						2a. DATE OF DEATH Month Day Year April 21 1968			2b. HOUR M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH 8-6-86			6. AGE (in years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Sudley		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A-H.					
10 CITY OR TOWN OF DEATH West River			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Housesville			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housesville			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Res. dence before admission) STATE West River		13b. COUNTY AA		13c. CITY OR TOWN West River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14 FATHER'S NAME First Middle Last Thomas Franklin SIMMONS				15 MOTHER'S MAIDEN NAME First Middle Last IDA CRANDELL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. ---		17 INFORMANT Address S. Aubrey SIMMONS West River Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4369 IMMEDIATE CAUSE (a) Cerebro-vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis - DUE TO, OR AS A CONSEQUENCE OF (c) malnutrition											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1x Severe osteoarthritis of spine											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1933 , to 4 21 , 19 68 , that (I) (we) last saw the deceased alive on 4-21 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Emily H. Wilson						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-22-68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-23-68		23c. NAME OF CEMETERY OR CREMATORY 202020		23d. LOCATION (City or Town) (County) (State) Housesville AA Md					
24. FUNERAL DIRECTOR ADDRESS Bernard Hardesty Ltd Housesville Md						25a. REC'D BY REGISTRAR DATE APR 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

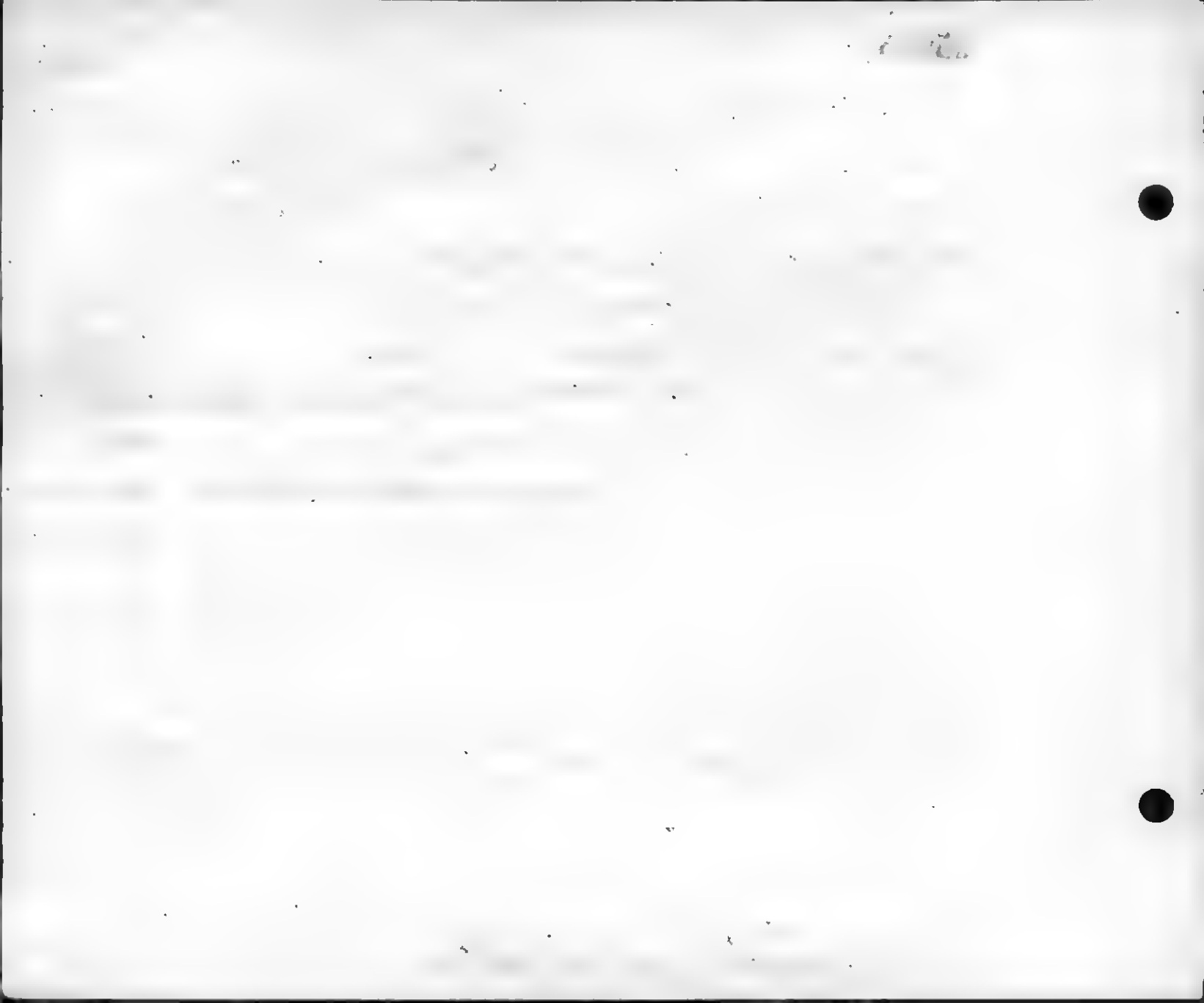


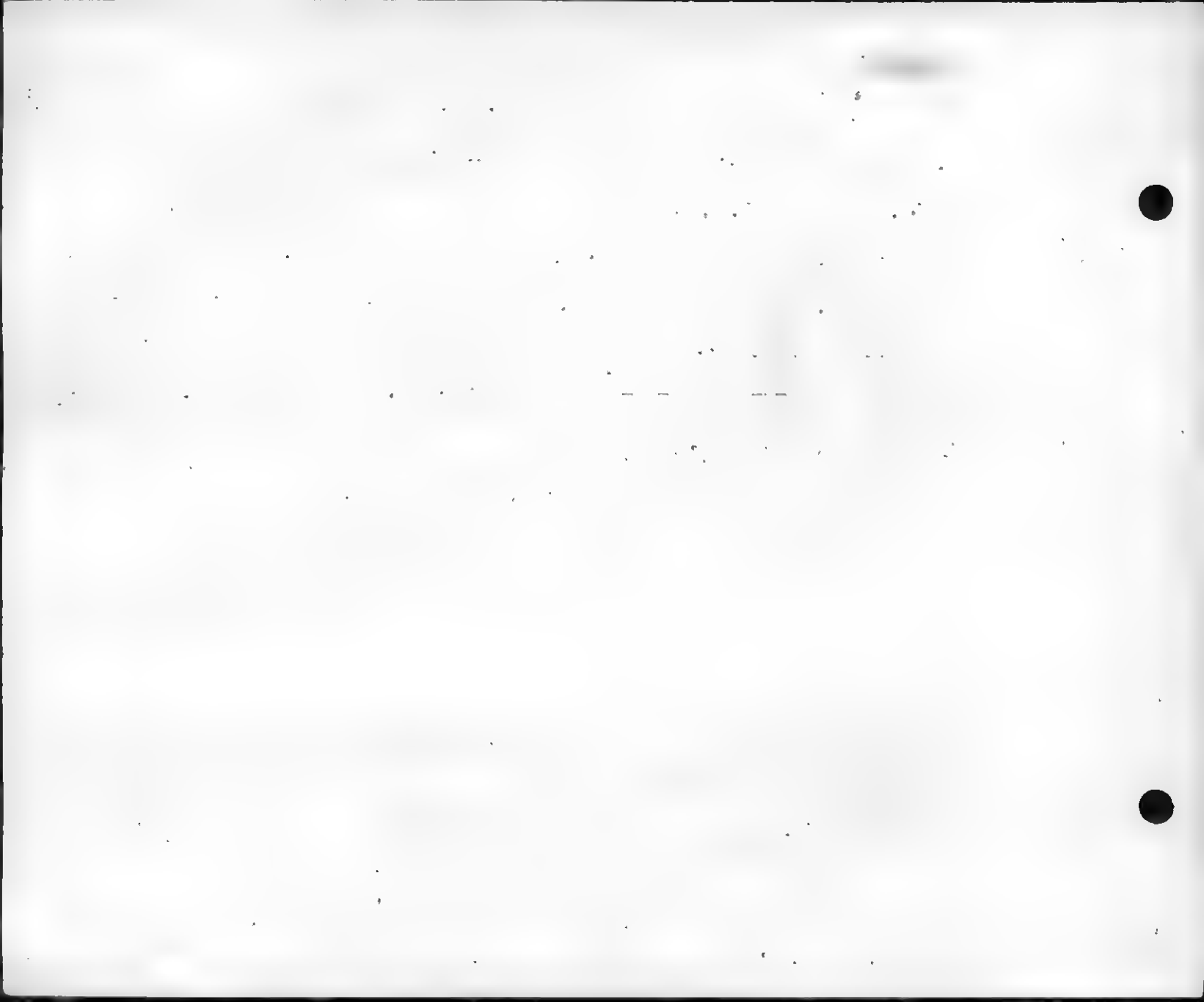
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A154
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
05055															
05057															
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR				
Joseph Butler									Month 4 Day 2 Year 68		5:30 AM				
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Negro		8-14-1888				79 YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md			
Maryland			U.S.A.					Anne Arundel Co.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Helen Buckner			Plaza Memorial Hospital				Working in Hotels								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER						
Md.			St. Marys												
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last			
William C. Butler									Virginia Mason						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address						
No			212-07-3700			Sadie Thomas (Wife)			5009 Lakeland Rd.			College Park Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:										3 days.					
IMMEDIATE CAUSE (a) Cerebral Hemorrhage															
DUE TO, OR AS A CONSEQUENCE OF															
(b) Hypertension of Heart & Dissection												Unknown			
DUE TO, OR AS A CONSEQUENCE OF															
(c) Senility												Unknown			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
442 x															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)											
		HOUR A.M. Month Day Year P.M. 19													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No		City or Town		County State					
22a. I certify that (I) (this hospital) attended the deceased from 9-1, 1960, to 4-1, 1968, that (I) (we) last saw the deceased alive on 4-1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE										DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Richard H. Heart															
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS					
Richard H. Heart										11721 Cherrington, Glen Burnie Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
		4-6-68		Harmony Mem Park		Highland Park				Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
H. S. Washington		4925 Deane St		APR 5 - 1968		Charles Judge									



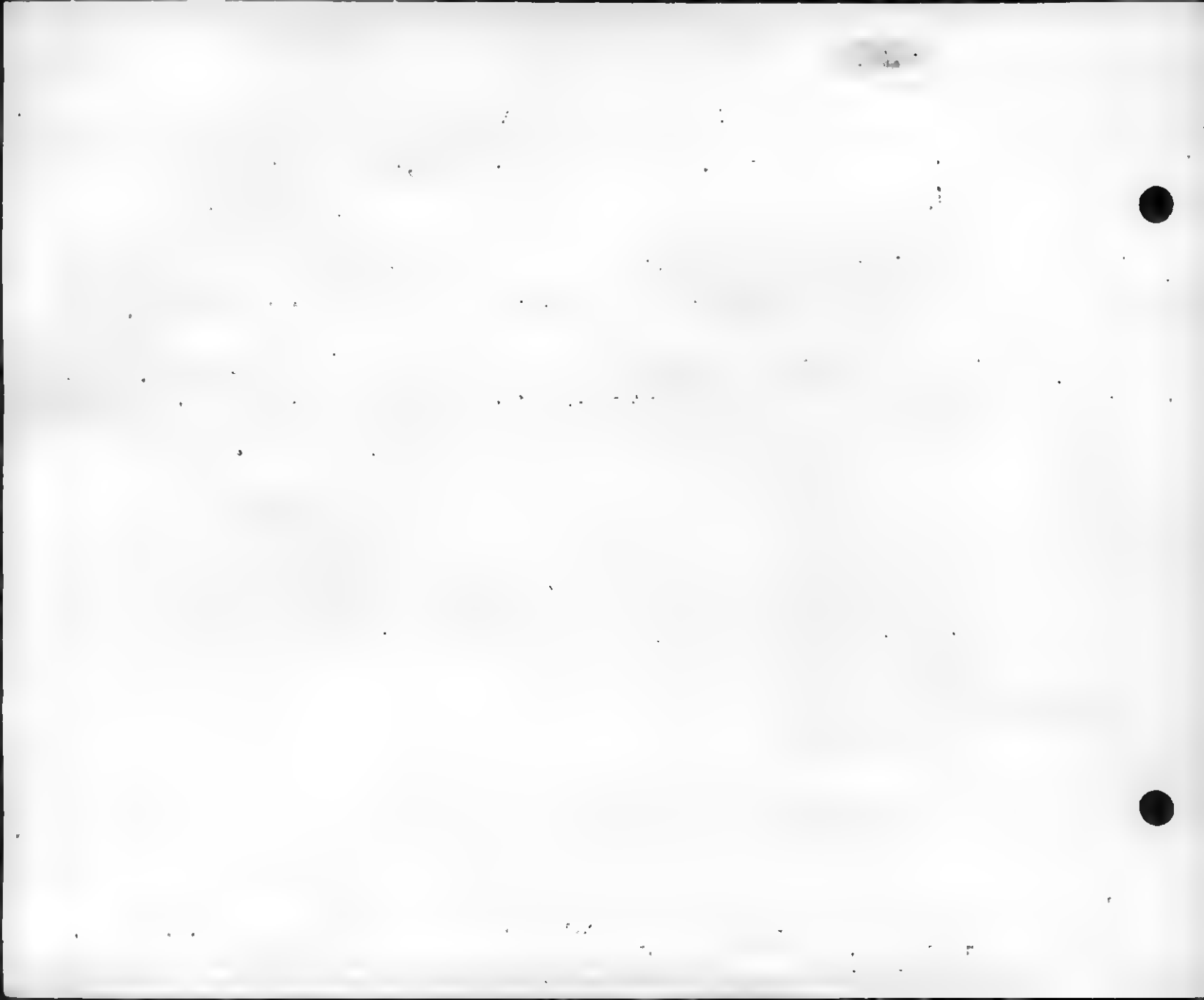


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304A REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M		
EVA HELEN CHANEY						April 18 1968					
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
female		caus.		July 19, 1896			71 YRS				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Anne Arundel Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Gambrills			Rt 175			housewife			own home		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Anne Arundel		Odenton		X		1131 Odenton Rd.		
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
William Hood			Carrie Lowman			468 Oakton Ave.,					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT						
no			212-16-5563D		Mrs. Hilda Chaney - Odenton, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinomatous primary sigmoid colon.</i> 1533 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1533 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hypoproteinem secondary anemia. avitaminosis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
9-21-1967		Bowel obstruction		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
Albert J. Cooper M.D.		4-19-68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Albert J. Cooper M.D.		206 Acorn Highway, S.H. Glen Burnie, Maryland.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		4/22/68		Nicholas Bethel		Odenton A.A. Md.					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Beverley E. Hopping		DATE		APR 22 1968		Richard Judge					
Hopping Funeral Home - Annapolis, Md.											



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First <i>David</i> Middle <i>Paul</i> Last <i>Clark</i>			2a. DATE KNOWN OF DEATH Month <i>4</i> Day <i>23</i> Year <i>1968</i>			2b. HOJR P M			
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>1/30/23</i>	6 AGE (In years last birthday) <i>5</i> YRS	F UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month <i>4</i> Day <i>23</i> Year <i>1968</i>	2d. HOJR <i>P</i> M
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>ANNE</i> Md			
10. CITY OR TOWN OF DEATH <i>Pasadena, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>21122 Oak North. ARCADEL.</i>		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>ANNE</i>		13c. CITY OR TOWN <i>Pasadena, Md</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>405 Saurbacker Road</i>	
14. FATHER'S NAME First <i>Robert</i> Middle <i>A.</i> Last <i>Clark</i>			15. MOTHER'S MAIDEN NAME First <i>Margaret</i> Middle <i>Leate</i> Last <i>Leate</i>			16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			
16b. SOCIAL SECURITY NO			17. INFORMANT <i>Mrs. Margaret Clark</i>			ADDRESS <i>Pasadena, Md. 405 Saurbacker Road</i>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Drowning</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) (d) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Swimmer</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>P.M.</i> <i>4/23 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>apparently fell into water from a boat.</i>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Green Lane</i>		21f. LOCATION Street or R.F.D. No City or Town County State <i>1 ANNE MD</i>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. Linhardt</i> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>4-23-68</i>			
EXAMINER'S NAME (Type) <i>E. Linhardt</i>			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) <i>ANNE</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/28/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		23d. LOCATION (City or Town) (County) (State) <i>Ritchie Highway A. A. Co. Md.</i>			
24. FUNERAL DIRECTOR <i>McCully Funeral Home</i>				237 Patapsco Ave. 21225		25a. REC'D BY REGISTRAR <i>MAY 01 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

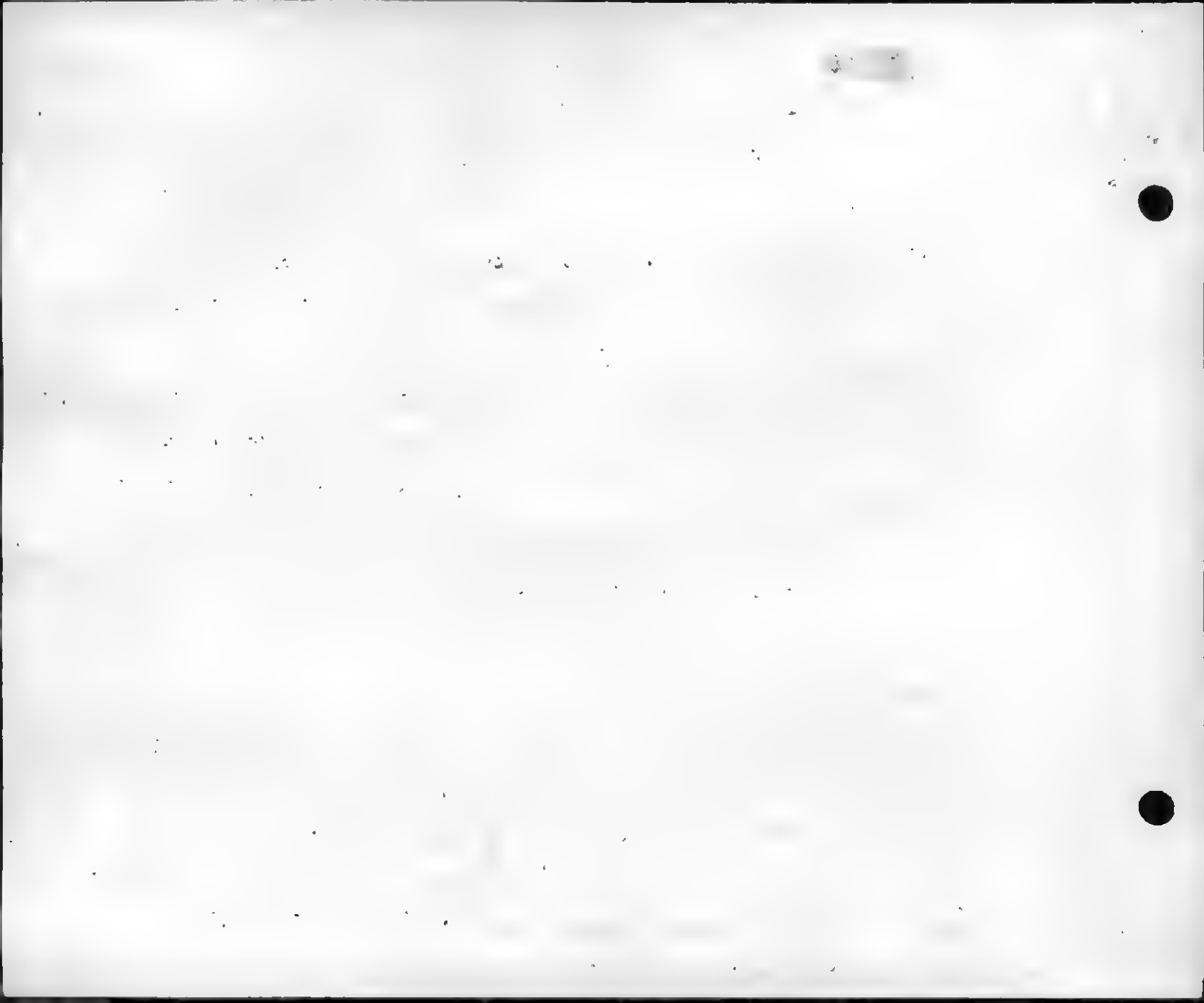
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 6 Film G400

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Wallace Copney			2a. DATE OF DEATH Month Day Year 4 21 68			2b. HOUR 1:51p M	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 9/3/97		6. AGE (In years last birthday) 71 10 YRS	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md	
10. CITY OR TOWN OF DEATH Crownsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Market worker	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME First Middle Last Charles Copney			15. MOTHER'S MAIDEN NAME First Middle Last Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, Crownsville State Hosp. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malnutrition and Dehydration Intractable Diarrhea</u> 153.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma of colon; acute gastro enteritis, etiology?</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cardiac arrhythmia, history of Tuberculosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/23</u> , 19 <u>68</u> , to <u>4/21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/21</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>L. Benedict, M.D.</u>						22c. DATE SIGNED 4/21/68	
22d. PHYSICIAN'S NAME (Type) L. Benedict, M.D.						22e. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-3-68		23c. NAME OF CEMETERY OR CREMATORY V.O.F.M.D. MED. SCHOOL		23d. LOCATION (City or Town) (County) (State) BALTIMORE MD	
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE MAY 6 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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35000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Alfred John DAGGETT, Sr.			2a. DATE OF DEATH Month Day Year April 18 1968			2b. HOUR P. 4:30 M	
3 SEX M		4 RACE W		5. DATE OF BIRTH 8-2-1904		6. AGE (In years last birthday) 63 YRS.	
7a. BIRTHPLACE (State or foreign country) MASS.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) H.A. General Hospt.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TRAINER		12b. KIND OF BUSINESS OR INDUSTRY HORSES	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.		13b. COUNTY AA.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1600 Bay Ridge Ave.	
14. FATHER'S NAME First Middle Last JOHN Daggett			15. MOTHER'S MAIDEN NAME First Middle Last MARY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. —		17. INFORMANT Address CATHERINE W. Daggett #13E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of larynx 11 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 yrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2/1 , 19 65 , to 4/18 , 19 68 , that (I) (we) last saw the deceased alive on 4/18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE Gene D. Trettin		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/19/68	
22d. PHYSICIAN'S NAME (Type) Gene D. Trettin, M.D.		22e. ADDRESS 16 Murray Ave., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-22-68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) (County) (State) Annapolis AA. MD.	
24. FUNERAL DIRECTOR John M. ...		ADDRESS ... Annapolis, Md.		25a. REC'D BY REGISTRAR APR 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



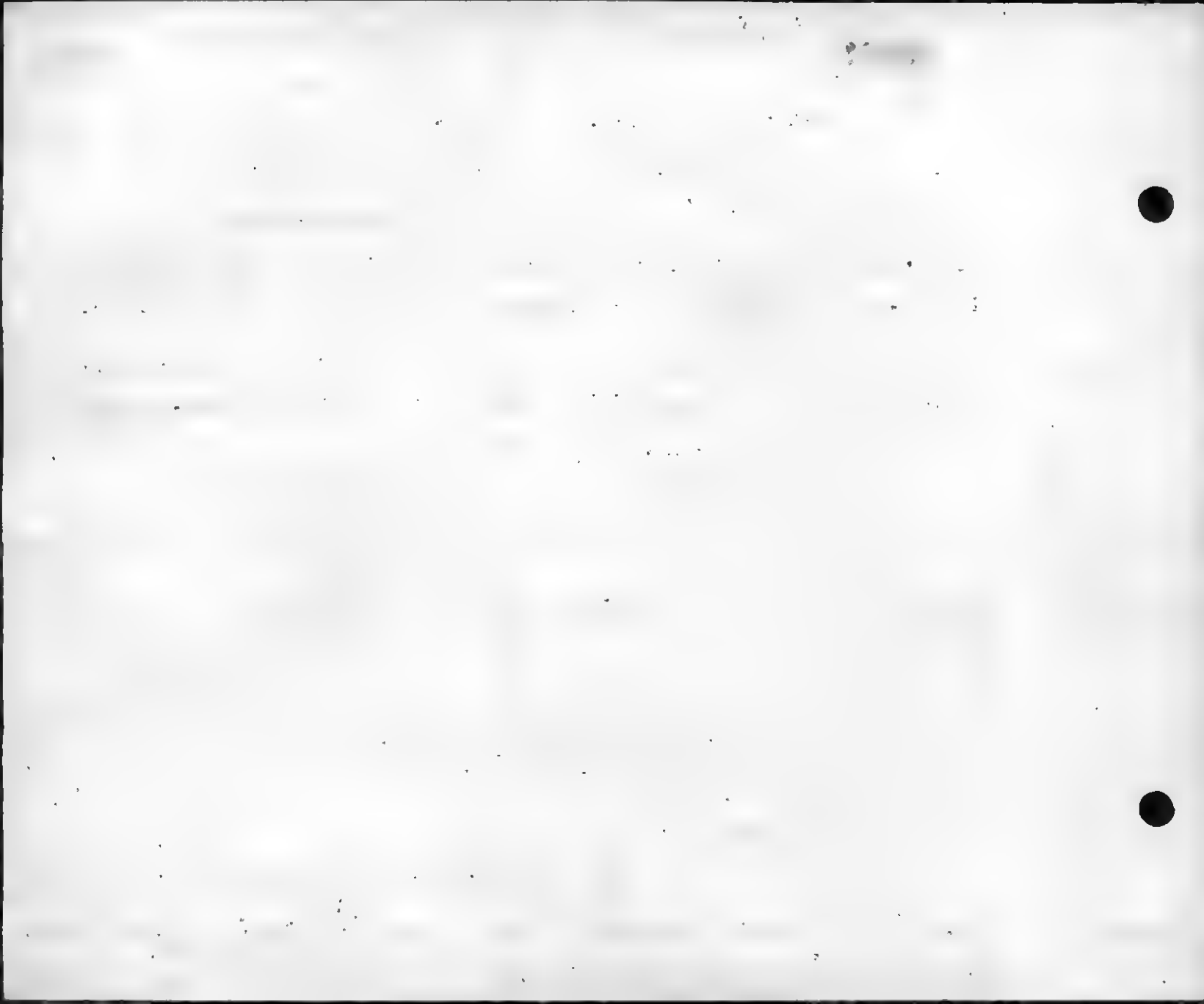
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Aruthur Eugene Davies						Month	Day	Year	11:05 AM		
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR		IF UNDER 24 HRS			
Male	White	8/18/78		89		MONTHS		DAYS		MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md			
Connecticut		USA				Anne Arundel					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Crownsville		Crownsville State Hosp.		Retired		BOAT Building					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIM 15?		13d. STREET AND NUMBER					
Maryland		Annapolis		YES <input type="checkbox"/> NO <input type="checkbox"/>		1016 Van Buren Street					
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Unknown						Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
No		214-05-0437A		Hospital Records, Crownsville Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cachexia											
DUE TO, OR AS A CONSEQUENCE OF											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Old pulmonary TBC. Pulmonary emphysema ASCVD											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No.		City or Town		County	State
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work											
22a. I certify that (1) (this hospital) attended the deceased from 3/27, 1968, to 4/3, 1968, that (1)-(we) last saw the deceased alive on 4/3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
L. Benedict, M.D.		4/3/68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
L. Benedict, M.D.		Crownsville State Hospital, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		County		State	
Burial		4-6-68		HILLCREST		Annapolis		Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
John M. Long		DATE APR 8 - 1968		John M. Long							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Vincent					Denny	April 24, 1968		4 AM	
SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Negro		7-3-1917		50 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD		U.S. A.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Shady Side						Laborer			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD			Anne Arundel			Shady Side			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Joseph Henry Wenny			Margaret S Savoy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
						Margaret S. Denny Shady Side			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction									
+109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Immediate years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Alcoholism; convulsive seizure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1961 to April 24, 1968, that (I) (we) last saw the deceased alive on April 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Willard F. Smith						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/24/68	
22d. PHYSICIAN'S NAME (Type) Willard F. Smith MD						22e. ADDRESS Shady Side, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) State			
Burial		4-27-1968		Ebenezer		Halesville Md.			
24. FUNERAL DIRECTOR William Reese # Anna M. M.						25a. REC'D BY REGISTRY APR 25 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

05063

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05065

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
John			Louis	Dunkas	Month 4 Day 9 Year 68			7:35pM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male		White		1/1/1919		49		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Baltimore		USA				Anne Arundel				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Crownsville		Crownsville State Hospital				None		none		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				332 W. Camden Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
John L.			Dunkas Sr.		ANNA VISCHITE			Unkown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address		
Yes			219-01-8480		Hospital Records, Crownsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>Diabetes mellitus</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		City or Town County State		
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>4/3</u> , 19 <u>68</u> , to <u>4/10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED
										4/10/68
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
L. Benedict, M.D.						Crownsville State Hosp., Crownsville, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			4/13/1968		Holy Redeemer Cem.		Bacto, Md.			
24. FUNERAL DIRECTOR						ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
John J. Cowan & Son, Inc. 901 Hollins St. Balt. Md.								APR 11 1968		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) First Middle Last George C. ELDRED					2a DATE OF DEATH Month Day Year April 25, 1968		2b HOUR P. 8:10 M.		
3 SEX Male		4 RACE White		5 DATE OF BIRTH JAN. 26, 1906		6 AGE (In years last birthday) YRS. 62		IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) ARKANSAS		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County Md.			
10 CITY OR TOWN OF DEATH ANNAPOLIS		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DCHA. A. GEN. HOSP. CARE CENTER		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CONST.		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MD		13b. COUNTY A. A. Co. ANNAPOLIS		13c CITY OR TOWN ANNAPOLIS		13d. WIDE CITY LIM TSP? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1701 CEDAR PARK RD.	
14 FATHER'S NAME First Middle Last WILLIAM ELDRED					15. MOTHER'S MAIDEN NAME First Middle Last DOCIA WOODSON				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address MRS. PEARL A. ELDRED #13A					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute dilatation of the heart DUE TO, OR AS A CONSEQUENCE OF Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Thrombosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 790.00								PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)	
9a DATE OF OPERATION		9b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from 19 68 , 19 1968 , to 1968 , 19 1968 , that (I) (we) last saw the deceased alive on 4/25/68 , 19 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Albert L. Anderson, M.D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 4/25/68			
22d PHYSICIAN'S NAME (Type) Albert L. Anderson, M.D.				22e ADDRESS 44 Southgate Avenue, Annapolis, M.D.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 4/28/68		23c NAME OF CEMETERY OR CREMATORY CEDAR BLUFF CEM.		23d LOCATION (City or Town) (County) (State) ANNAPOLIS A.A. Co MD			
24 FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD.				ADDRESS		25a RECORD REGISTRAR APR 30 1968		25b REGISTRAR'S SIGNATURE J. J. J. J.	

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT

TO INPUT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
William Porter		Fleishman						Month 4 Day 21 Year 1968		P M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER YEAR		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
M	W	8/19/28	39 YRS	MONTHS DAYS		HOURS MIN		Month 4 Day 21 Year 1968		P M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 COUNTY OF DEATH					
Louisia, Va.		USA		WIDOWED		DIVORCED		A.A.C.U.		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Annapolis		DVA - Anne Arundel Co		Printer							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Virginia 22201		Arlington County		Arlington		YES NO		801 N. Jackson St			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Otis Franklin Fleishman				Lucie Shealor							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
XXXXXX Yes Korea				577-30-8210		Otis F. Fleishman		801 N. Jackson St Arlington, Virginia			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac disease</u>										Sweden	
4d17 DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
4-34											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES NO			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)							
CAUSE OF DEATH		HOUR A.M. P.M.		19							
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
ACTUAL SIGNATURE		E. Linhardt		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		F. Linhardt								4-21-68	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		4/25/1968		Columbia Gardens Cem.		Arlington, Virginia					
24. FUNERAL DIRECTOR		301 N. Fairfax St		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Arlington Funeral Home		Arlington, Va.		DATE		APR 25 1968		Charles Judge			



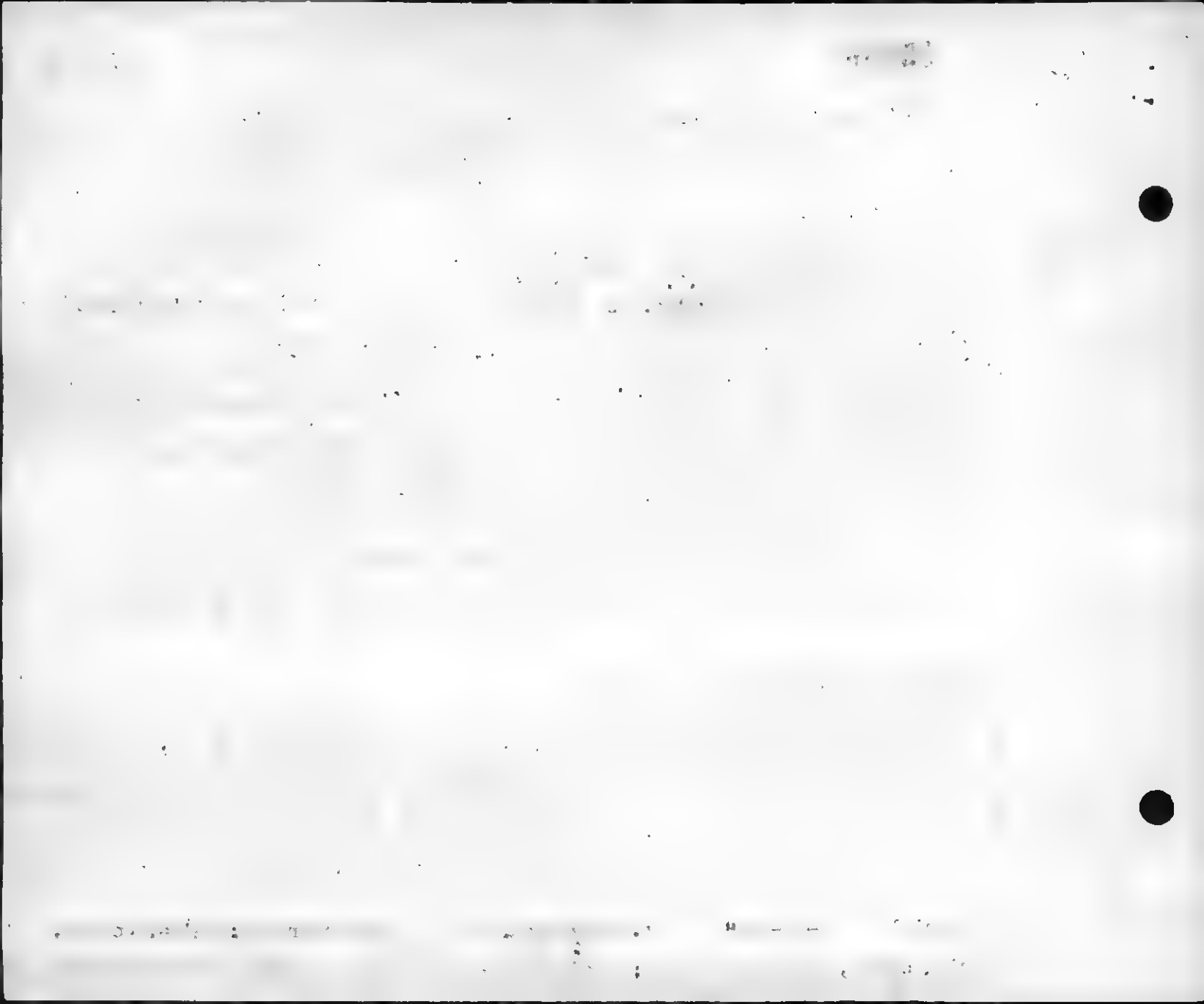
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <i>Alfred C Fryfogel</i>			2a. DATE OF DEATH Month Day Year <i>April 14 1968</i>			2b. HOUR <i>7:40 P M</i>			
3 SEX <i>M</i>		4 RACE <i>W</i>		5 DATE OF BIRTH <i>02/22/82</i>		6 AGE (In years last birthday) <i>86</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Randallstown, Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>AA</i>			
10. CITY OR TOWN OF DEATH <i>Linthicum</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>115 Patricia Ave</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Farming</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Baltimore Co</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>115 Patricia Ave; 21090</i>			
14. FATHER'S NAME First Middle Last <i>John Fryfogel</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Margaret Miller</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>219-10-2280</i>		17. INFORMANT <i>Betty Freisheim</i>		Address <i>same</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pericardial Effusion</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Renal Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>4 days</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>May 1966</i> to <i>4/14</i> , 1968, that (I) (we) last saw the deceased alive on <i>4/14</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <i>Chas. L. Ball Jr. M.D.</i>					DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/14/68</i>
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS <i>Linthicum, Md</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-17-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Old court Rd; Balto. Co; Md.</i>			
24. FUNERAL DIRECTOR <i>Loring Byers, 8728 Liberty Rd; Randallstown</i>				ADDRESS <i>M 21133</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



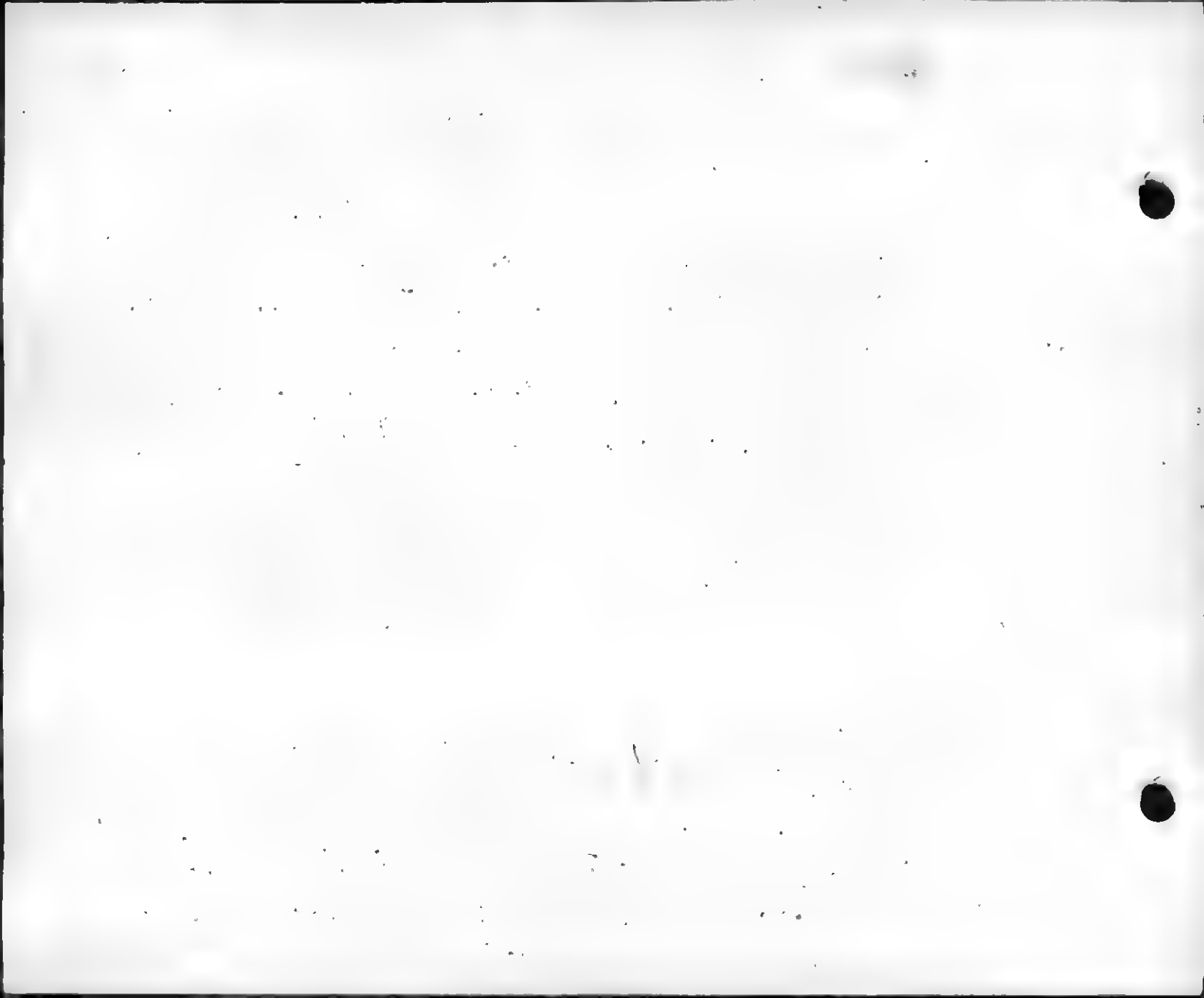
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-78)
30M REV 1-68

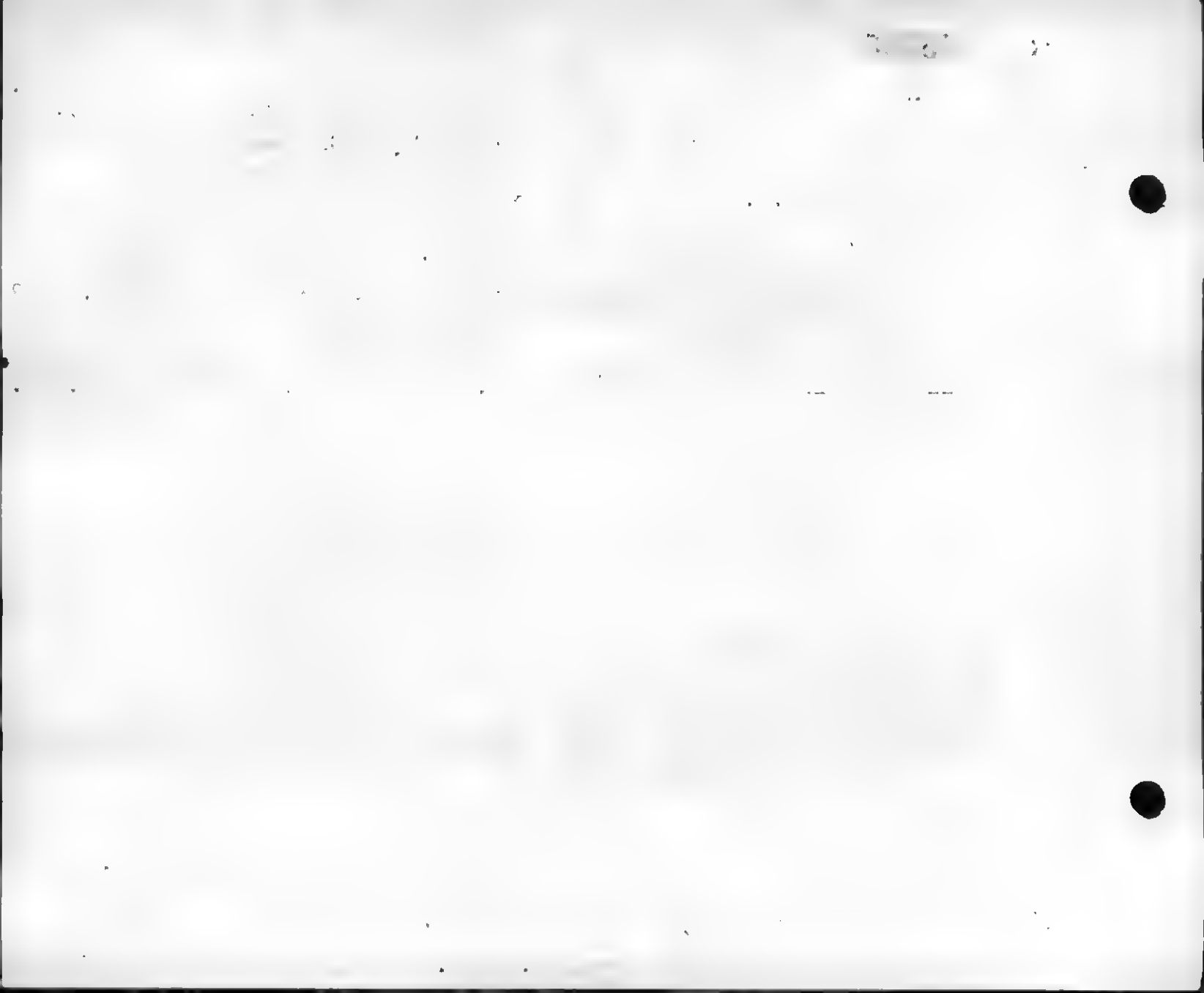
MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
Andrew				Geisser	April 7 1968		6:25 AM		
3. SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
male	white		9-1-33		74 YRS.				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md		
Germany	USA				A.A.				
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Glen Burnie	North Arundel Hosp.		Cook						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.	Baltimore		Baltimore				601 S. Payson St.		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
UNK		ANDREW			UNK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
No				Family		3 Birch Ave - Glen Burnie, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>tumor @ third rib</u> 2381 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 138x Pneumonia									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 4/5/1968, to April 7, 1968, that (I) (we) lost saw the deceased alive on April 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b SIGNATURE		J. B. Ramirez MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 4/7/68	
22d. PHYSICIAN NAME (Type)		J. B. RAMIREZ MD		22e ADDRESS		3127 Ann Appls Rd Balto 27 325 Hospital Dr Balto 201 G13			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
Burial		APR 10-68		Cedar Hill Cem		Balto		21225 Md	
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REQUESTOR		25b. REGISTRAR'S SIGNATURE			
John H. Hahn Funeral Home		4200 Pennington Ave. 21224		APR 10 1968		Charles Judge			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 05068 MARYLAND STATE DEPARTMENT OF HEALTH </div> <div style="display: flex; justify-content: space-between;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05072 </div> <h2 style="text-align: center; margin: 0;">CERTIFICATE OF DEATH</h2>																													
1. DECEASED NAME (Type or print)			First Ella			Middle GEMILL			Last GEMILL			2a. DATE OF DEATH Month April			Day 6			Year 1968			2b. HOUR 9:25			P. M					
3 SEX Female			4 RACE White			5 DATE OF BIRTH April 4, 1894			6 AGE (In years last birthday) 74			7 UNDER 1 YEAR MONTHS 			8 UNDER 24 HRS. DAYS 			HOURS 			MIN 								
7a. BIRTHPLACE (State or foreign country) Nebraska			7b. CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.																				
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY Seamstress																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 374 1/2 Aberdeen Rd. Rt 3																	
14. FATHER'S NAME First John			Middle Johnson			Last 			15. MOTHER'S MAIDEN NAME First Hannah			Middle Johnson			Last 														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) 			16b. SOCIAL SECURITY NO. 212 01 4892			17. INFORMANT Mrs. Katherine Hanson Address 374 1/2 Aberdeen Rd. Rt 3 Anna. Md.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetected Cancer															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1192 Cerebral arteriosclerosis																													
9a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No			City or Town			County			State														
22a. I certify that (I) (this hospital) attended the deceased from 4/1 , 19 68 , to 4/6 , 19 68 , that (I) (we) lost saw the deceased alive on 4/6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE E. G. B. 1															DEGREE 			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4/8/68		
22d. PHYSICIAN'S NAME (Type) Gemma A. Chunnell			22e. ADDRESS 121 Cathedral St., Annapolis, Md.																										
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE Apr. 10 1968			23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.			23d. LOCATION (City or Town) Dorsey			(County) Maryland			(State)														
24. FUNERAL DIRECTOR Beall Funeral Home			ADDRESS 1212 West St. Anna.			25a. REC'D BY REGISTRAR APR 10 1968			25b. REGISTRAR'S SIGNATURE Charles Judge																				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

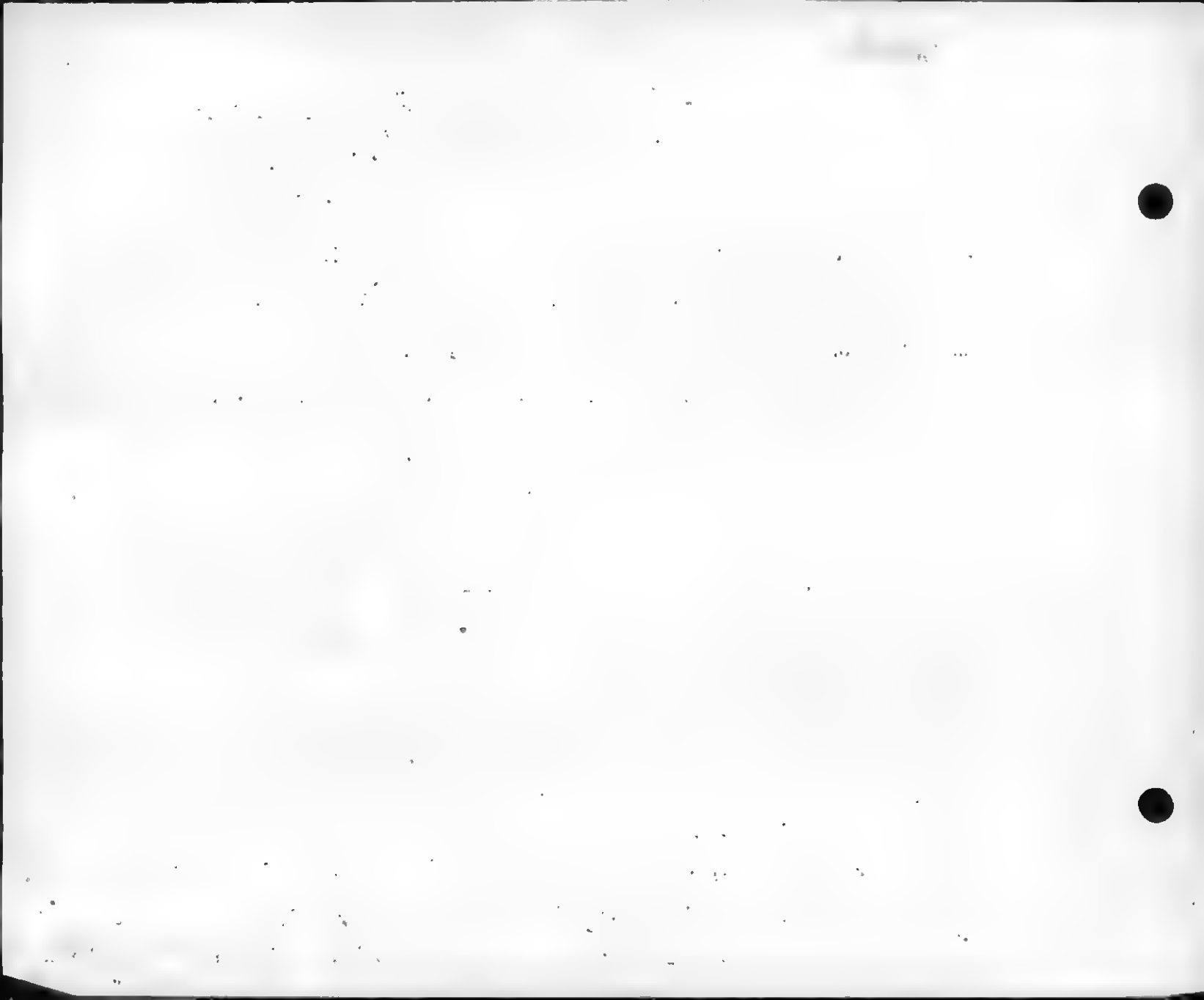
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD
05068

MD
05068

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) MICHAEL GERAGHTY		First Michael Middle Geraghty Last Geraghty		2a. DATE OF DEATH Month April Day 9 Year 1968		2b. HOUR 20:55 PM	
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH MARCH 6, 1901		6. AGE (In years last birthday) 67 YRS	
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A. W. ARUNDEL	
10. CITY OR TOWN OF DEATH FT. LAUD, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ARMED HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. ARMY		12b. KIND OF BUSINESS OR INDUSTRY MILITARY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND 13b. COUNTY ARMED		13c. CITY OR TOWN PASADENA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER BOX 223, ROUTE #7	
14. FATHER'S NAME First PATRICK Middle Geraghty Last Geraghty				15. MOTHER'S MAIDEN NAME First MARY ANN Middle McGowan Last McGowan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-10-9633		17. INFORMANT Address R. L. BROWN 223 DULCESHIP RD., PASADENA, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 1530 DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF ILEOCAECAL VALVE 32 MOS. DUE TO, OR AS A CONSEQUENCE OF (c) 1530							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) STOMACH ULCER WITH BLEEDING URINARY OBSTRUCTION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 20 MARCH, 1968 , to 9 APRIL, 1968 , that (I) (we) last saw the deceased alive on 9 April , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Carl G. Thies						22c. DATE SIGNED 4-9-68	
22d. PHYSICIAN'S NAME (Type) DELLIS K. GALINSKY, CAPT MC				22e. ADDRESS ARMED HOSPITAL, FT. LAUD, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-15-68		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR Robert A. Baranowski				25a. REC'D BY REGISTRAR 16 1968		25b. REGISTRAR'S SIGNATURE Richard J. Judge	



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Charles						Lison		Month		Day	Year	P	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		F UNDER YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	N	9-21-1929		38 YRS.		MONTHS DAYS		HOURS MIN		Month Day Year		P	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		Md.			
Md.		U.S.A.		WIDOWED		DIVORCED		A.A.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis		41 Calvert											
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Md.		A.A.		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		41 Calvert					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
David		Smith				Lison		Margaret		Lison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		16c. INFORMANT		ADDRESS							
		214253461		Margaret Snowden		62 Calvert							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY.													
IMMEDIATE CAUSE (a) <u>Cardiovascular</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)													
19a. DATE OF OPERATION													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
20. AUTOPSY?													
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
CAUSE OF DEATH		19											
22. INJURY OCCURRED		22e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		22f. LOCATION Street or R.F.D. No		City or Town		County		State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b. DATE SIGNED					
EXAMINER'S NAME (Type)		F. L. Linhardt						4-15-68					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
Burial		4-23-1968		Dane Lawn		Annapolis		Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE							
William Reese		A.A. Md.		APR 22 1968		J. Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1594
304 REV. 1-68

<div>05072</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>05075</div>											
1. DECEASED-NAME (Type or print) <i>Edna L. Gruver</i>						2a. DATE OF DEATH Month <i>4</i> Day <i>6</i> Year <i>68</i>			2b. HOUR <i>12:15</i> M		
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>Jan 9, 1885</i>			6. AGE (In years last birthday) <i>83</i> -YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Balto</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md.					
10. CITY OR TOWN OF DEATH <i>Rockland Bay</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>602 Laurel Rd. Housewife</i>			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if not recd.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>House</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institut an- Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Severna Park</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>602 Laurel Road</i>		
14. FATHER'S NAME First Middle Last <i>(Unknown) Lappe</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Lexinia Zirkle</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) <i>No</i>				16b. SOCIAL SECURITY NO. <i>217-34-3676</i>		17. INFORMANT <i>MR Robert Gruver (son)</i>			Address <i>Same #13</i>		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAJSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>d.c.-v.d</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Senard</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , 19____, to <i>1968</i> , 19____, that (I) (we) lost saw the deceased alive on <i>4-7-68</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Robert R. Hahn MD</i>								22c. DATE SIGNED <i>4-6-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Robert R. HAHN</i>		22e. ADDRESS <i>Severna Park Md</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-9-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Louden Park Cemetery</i>		23d. LOCATION (City or Town) <i>Baltimore</i>		(County) <i>Md</i>		(State)	
24. FUNERAL DIRECTOR <i>E. B. Fleming</i>		ADDRESS <i>Singhston Funeral Home, Glen Burnie</i>		25a. REC'D BY REGISTRAR <i>APR 8 - 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

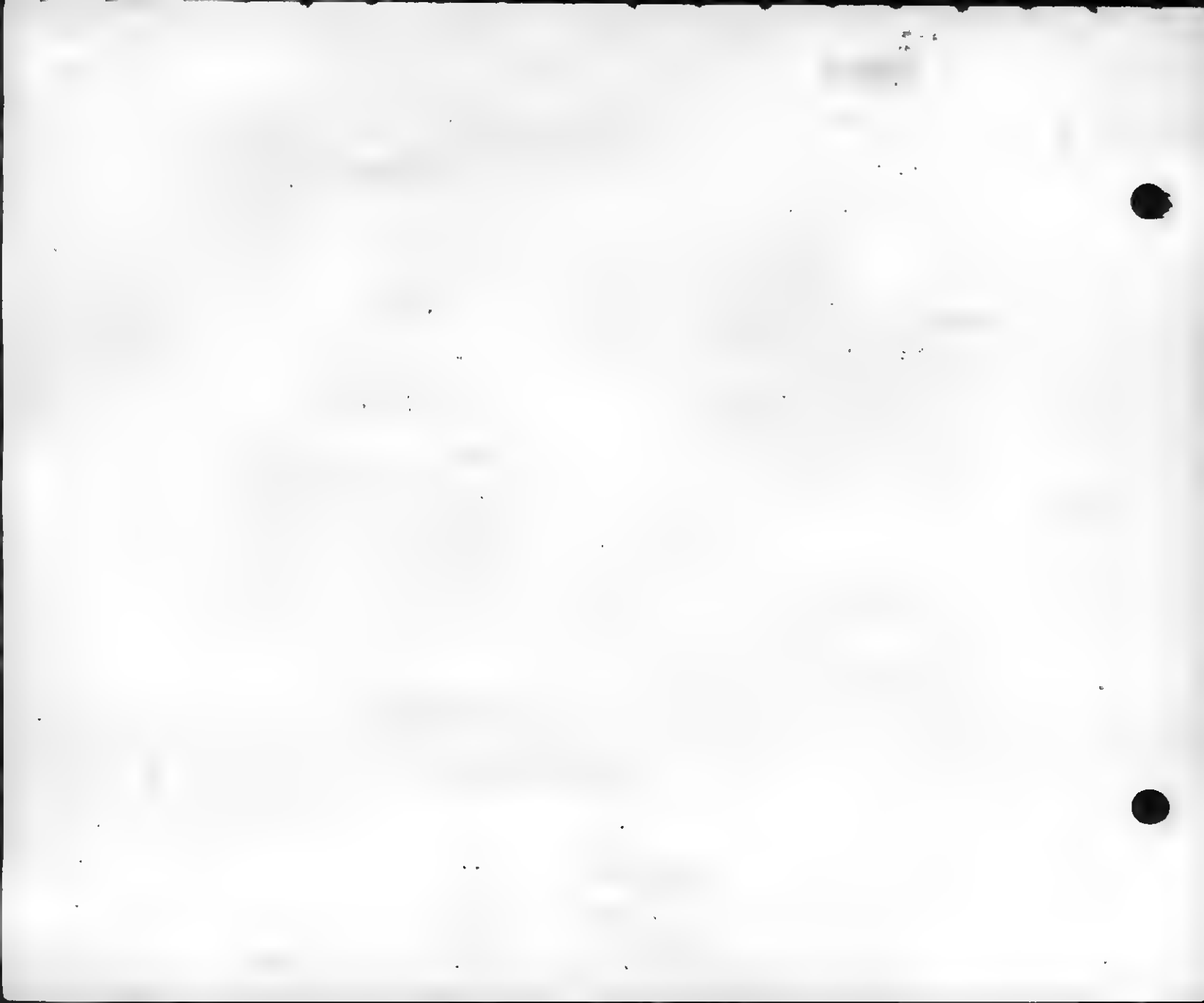


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05072
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY AA Co		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) STATE Md b. COUNTY AA Co		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena		d. STREET ADDRESS 7916 West End Dr		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert		First Robert		Middle J		Last Gwilliam		4. DATE OF DEATH Month Apr Day 19 Year 1968		5. SEX Male		6. COLOR OR RACE Cau	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 22, 1898		9. AGE (in years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward Gwilliam		14. MOTHER'S MAIDEN NAME Emily Jones		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Family	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Lung (Bronchogenic) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 18 mos.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from JAN 1964 to Apr. 19, 1968 , that (I) (we) last saw the deceased alive on 4/17 1968 , and that death occurred at 12 AM , from the causes and on the date stated above.		22a. SIGNATURE C. Earl Hill		22b. DATE SIGNED 4-19-68		22c. PHYSICIAN'S NAME (Typed) 395 FT. SMALLWOOD RD. PASADENA MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/22/69		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem Pk		23d. LOCATION (City, town or county) (State) Baltimore Co Md		24. FUNERAL DIRECTOR Mc Gilly F.H. 237 Fatassco Ave		25a. REC'D BY REGISTRAR APR 22 1968		25b. REGISTRAR'S SIGNATURE Charles Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05078
M
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MAYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Elizabeth Gertrude HAFNER			2a DATE OF DEATH Month Day Year April 8 1968			2b HOUR M 3:00	
3. SEX Female		4. RACE white		5. DATE OF BIRTH Aug 10, 1873		8 AGE (In years last birthday) 94	
7a BIRTHPLACE (State or foreign country) Illinois		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Anne Arundel	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) AA General		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY Md	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY AA		13c CITY OR TOWN Annapolis		13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 3744 Ramsdell Dr.							
14. FATHER'S NAME First Middle Last Henry Mott Holley			15 MOTHER'S M.A.D.E.N. NAME First Middle Last Violetta Brinkerhoff				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 219-54-4263		17 INFORMANT Mrs Donald Sharp			
				Address Annapolis Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident? DUE TO, OR AS A CONSEQUENCE OF (b) Enteric hemorrhage from hip DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11d.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Senility							
19a DATE OF OPERATION 3-28-68		19b CONDITION FOR WHICH OPERATION WAS PERFORMED AA hip		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING (If either, notify medical examiner) <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. Month Day Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) Fell at home			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home farm street, factory, office building etc.) home		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3-28-68 , 1968, to 4-8 , 1968, that (I) (we) last saw the deceased alive on 4-8 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE George W. Little		22c DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22e DATE SIGNED 4-8-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b DATE 4-8-68		23c NAME OF CEMETERY OR CREMATORY Lee Crematory		23d LOCATION (City or town) (County) (State) WASH D.C.	
24 FUNERAL DIRECTOR TA Hardisty		ADDRESS ANNAPOLIS, Md		25a REC'D BY REGISTRAR DATE APR 15 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME 15,
10M REV 1 68

05074

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <i>Cathy Jane</i>		First M. date Last <i>Hardesty</i>		2a. DATE KNOWN OF DEATH Month <i>4</i> Day <i>25</i> Year <i>68</i>		2b. HOUR <i>A</i> M	
3 SEX <i>F</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>7-26-57</i>	6 AGE (in years last birthday) <i>10</i> YRS	F UNDER 1 YEAR MONTHS DAYS HOURS MIN		F UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. C. T. ZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>A.A. CO.</i>	
10 CITY OR TOWN OF DEATH <i>ANNAPOLIS - MD</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>HOME - ARUNDEL 19014</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>STUDENT</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>SCHOOL</i>	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE <i>MD.</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>DAVIDSONVILLE</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First Middle Last <i>Preston M. Hardesty</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>CATHERINE. DOVE</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT <i>Preston M. Hardesty</i>		ADDRESS <i>#13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple injuries</i> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Swollen</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <i>11-4</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>4/25 1968</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Struck by auto</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <i>Highway</i>		21f. LOCATION Street or R.F.D. No City or Town County State <i>RR 214 - Union AG A.A. CO. MD</i>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>E. Linhardt</i>		EXAMINER'S NAME (Type) <i>E. Linhardt</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>4-25-68</i> <i>A.A. CO.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>4-27-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i>		23d. LOCATION (City or Town) (County) (State) <i>Bladensburg P.G. MD.</i>	
24. FUNERAL DIRECTOR <i>John M. Lykens</i>				ADDRESS <i>Annapolis, Md.</i>		25a. REC'D BY REGISTRAR <i>APR 30 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>John M. Lykens</i>			



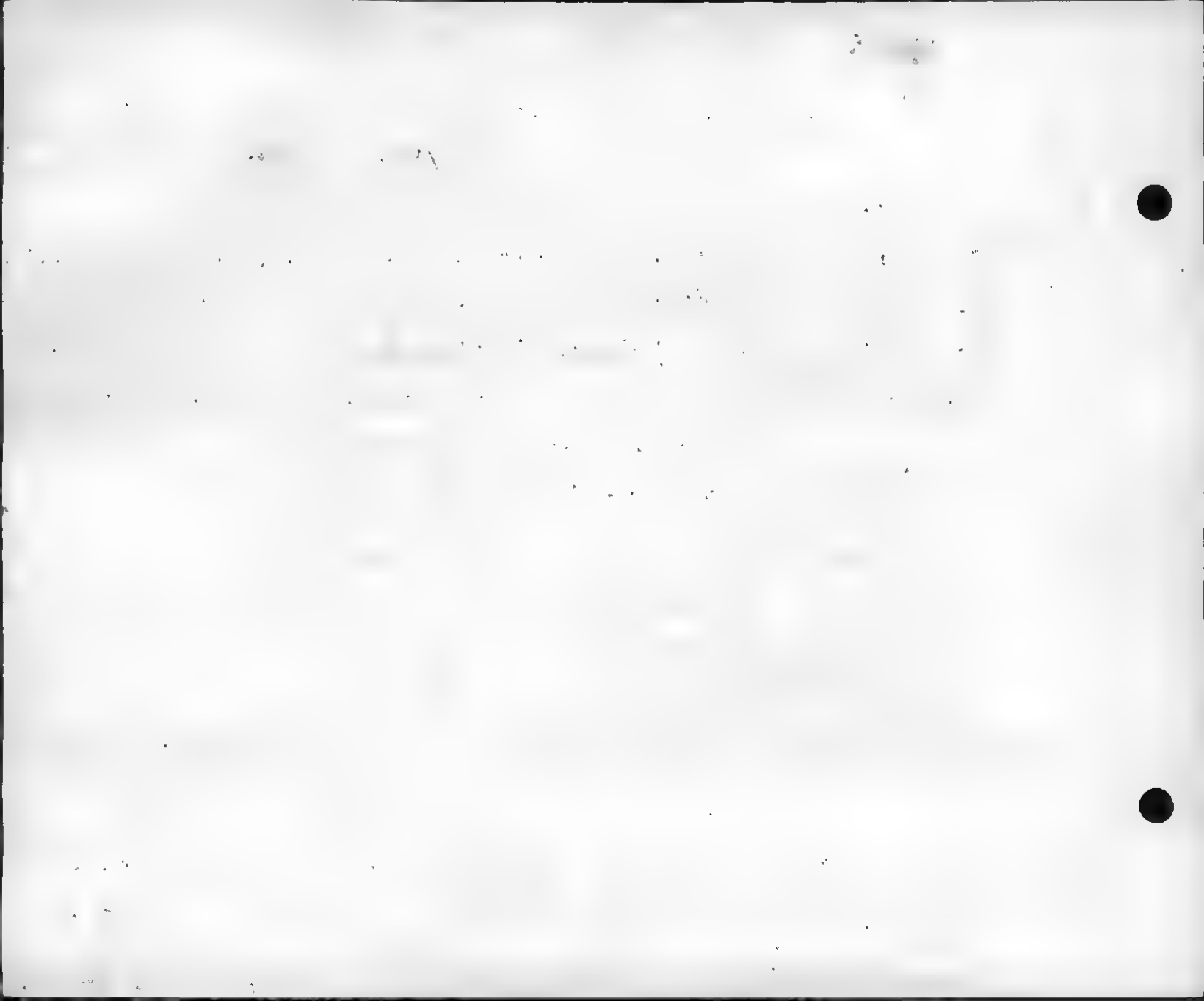
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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VR A15 41
304 REV 1/68

05075
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Richard Harmon			2a. DATE OF DEATH Month Day Year 4 22 68			2b. HOUR 3:50pm	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 9/7/1931		6. AGE (In years last birthday) 36 YRS	
7a. BIRTHPLACE (State or foreign country) unknown KENT. Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md	
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Unknown laborer		12b. KIND OF BUSINESS OR INDUSTRY VARIOUS	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY KENT. ✓		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER Unknown		14. FATHER'S NAME First Middle Last RICHARD Unknown HARMON		15. MOTHER'S MAIDEN NAME First Middle Last VIRGINIA Unknown CANN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) Unknown no		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, Crownsville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4104 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) +							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (H) (this hospital) attended the deceased from 7/7, 1959, to 4/22, 1968, that (H) (we) last saw the deceased alive on 4/22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L. Benedict, M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/22/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/27/1968		23c. NAME OF CEMETERY OR CREMATORY JAMES CEMETERY		23d. LOCATION (City or Town) (County) (State) CHESTERTOWN KENT. Md.	
24. FUNERAL DIRECTOR Semech...		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE APR 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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VR 115 (1)
30M REV 11/68

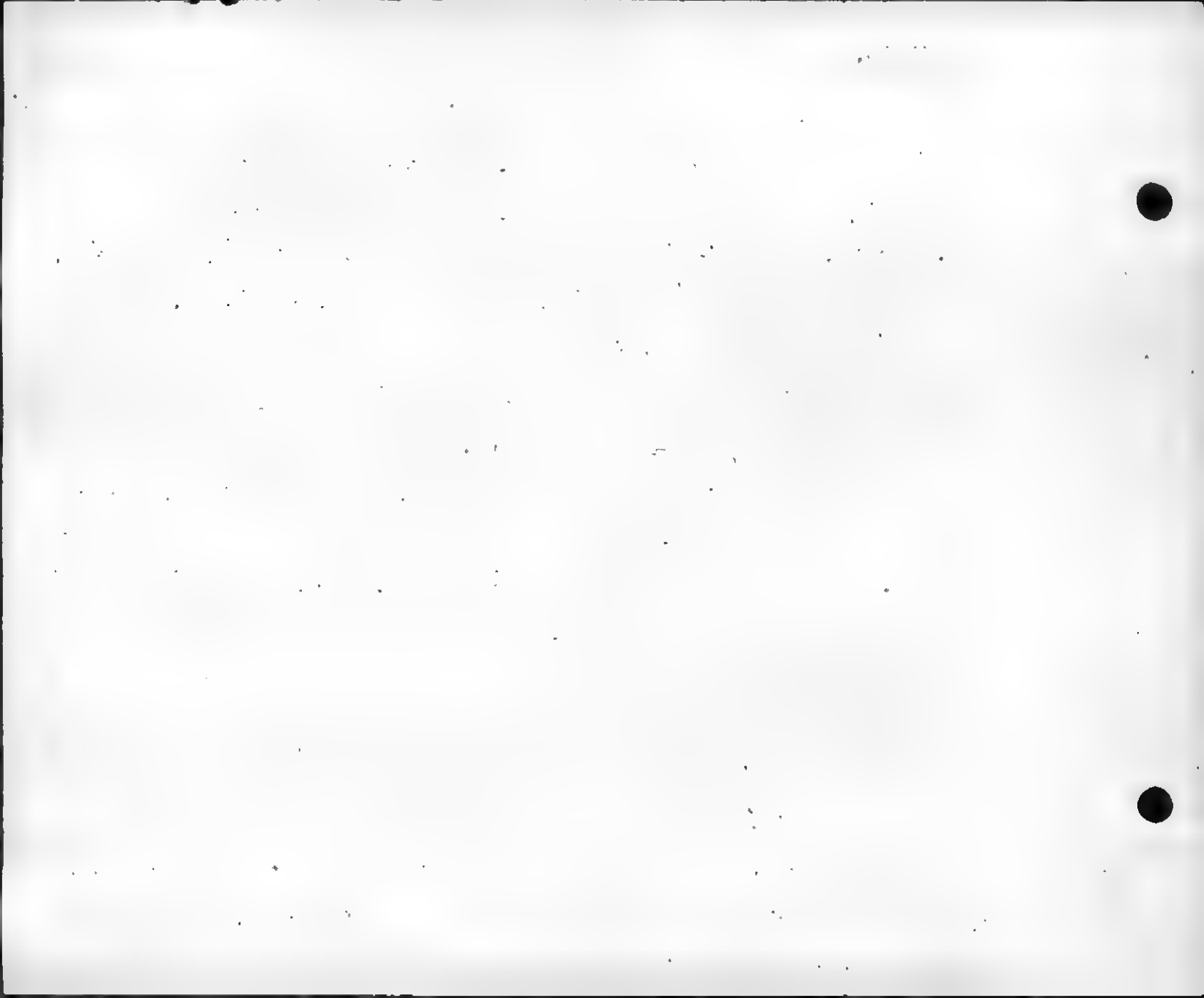
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05C76

CERTIFICATE OF DEATH

150811

1. DECEASED NAME (Type or print) Martha F HEINTZE			2a. DATE OF DEATH Month April Day 4 Year 1968			2b. HOUR 11:59 P.			
3. SEX F		4. RACE W		5. DATE OF BIRTH 3-31-1882		6. AGE (In years lost birthday) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) H. A. GENERAL HOSP.		12a. USJA. OCCUPATION (Kind of work done during most of work no life, even if retired) HOME WIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b. COUNTY H.A.		13c. CITY OR TOWN EDgewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER SILVER Run Road	
14. FATHER'S NAME First UNK Middle HAUSER Last HAUSER			15. MOTHER'S MAIDEN NAME First UNK Middle UNK Last UNK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO —		17. INFORMANT RICHARD HEINTZE #13		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Gram-negative septicemia 5990 DUE TO, OR AS A CONSEQUENCE OF (b) Urinary tract infection, E. coli & Herellia sp. DUE TO, OR AS A CONSEQUENCE OF (c) Inanition								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1 month 1 1/2 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Atrial fibrillation Decubital ulcers, multiple, Flaccid paralysis left arm Arteriosclerosis, Gangrene, both lower extremities, Cerebral thrombosis,									
19a. DATE OF OPERATION 2/20 & 3/21 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene both feet & L. leg		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) <input type="checkbox"/> OFFICE BUILDING, ETC. <input type="checkbox"/>		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb 18, 1968 , to April 4, 1968 , that (I) lost saw the deceased alive on April 4, 1968 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) see (d) did not view the body after death.									
22b. SIGNATURE Charles W. Kinzer						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 5, 1968	
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.				22e. ADDRESS 16 Murray Ave, Annapolis, Md. 21401					
23a. BURIAL, CREMATION, REMOVAL (Type) BURIAL		23b. DATE 4-8-68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) HADELSBURG P.G. MD.			
24. FUNERAL DIRECTOR John M. Lybo				ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR APR 8 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



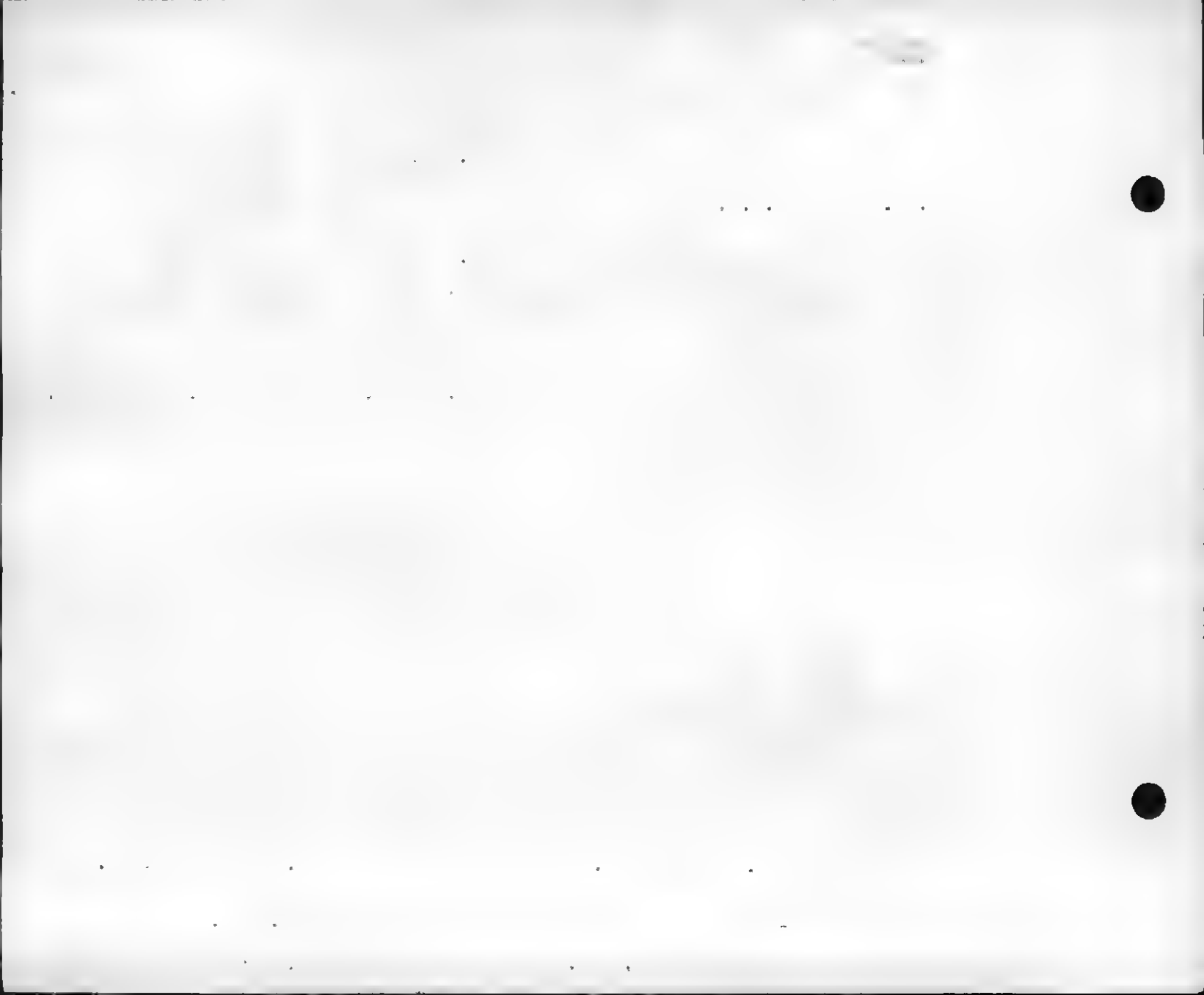
CERTIFICATE OF DEATH

05077

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) Nettie Reaves HENDERSON			2a DATE OF DEATH Month April Day 1 Year 1968			2b HOUR P. 10:10 M				
3 SEX Female		4 RACE W		5 DATE OF BIRTH Aug. 12, 1882		6 AGE (In years last birthday) 85 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) N. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.				
10 CITY OR TOWN OF DEATH Annapolis			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Annapolis General Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b KIND OF BUSINESS OR INDUSTRY	
13a U.S. RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland			13b COUNTY Anne Arundel		13c CITY OR TOWN Arnold, Md.		3d INS OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 111 Mage Vista Road,	
14 FATHER'S NAME First Middle Last George Reaves				15. MOTHER'S MAIDEN NAME First Middle Last Nancy Aikens						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO None		17 INFORMANT Address Helen H. Davis, Mage Vista Rd., Arnold, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bronchopneumonia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21a INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that (I) (the hospital) attended the deceased from 3/27/68 to 4/1/68 , that (I) (we) last saw the deceased alive on 4/1/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE Richard N. Peeler						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/2/68		
22d. PHYSICIAN'S NAME (Type) Richard N. Peeler, M.D.						22e ADDRESS 121 Cathedral St., Annapolis, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 4-4-68		23c NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d LOCATION (City or Town) (County) (State) Balto., Md.			
24 FUNERAL DIRECTOR 4101 Edmondson Avenue Witake Funeral Directors, Balto., Md. 21229						25a. REC'D BY REG STRAIP DATE APR 11 1968		25b REGISTRAR'S SIGNATURE Charles Judge		



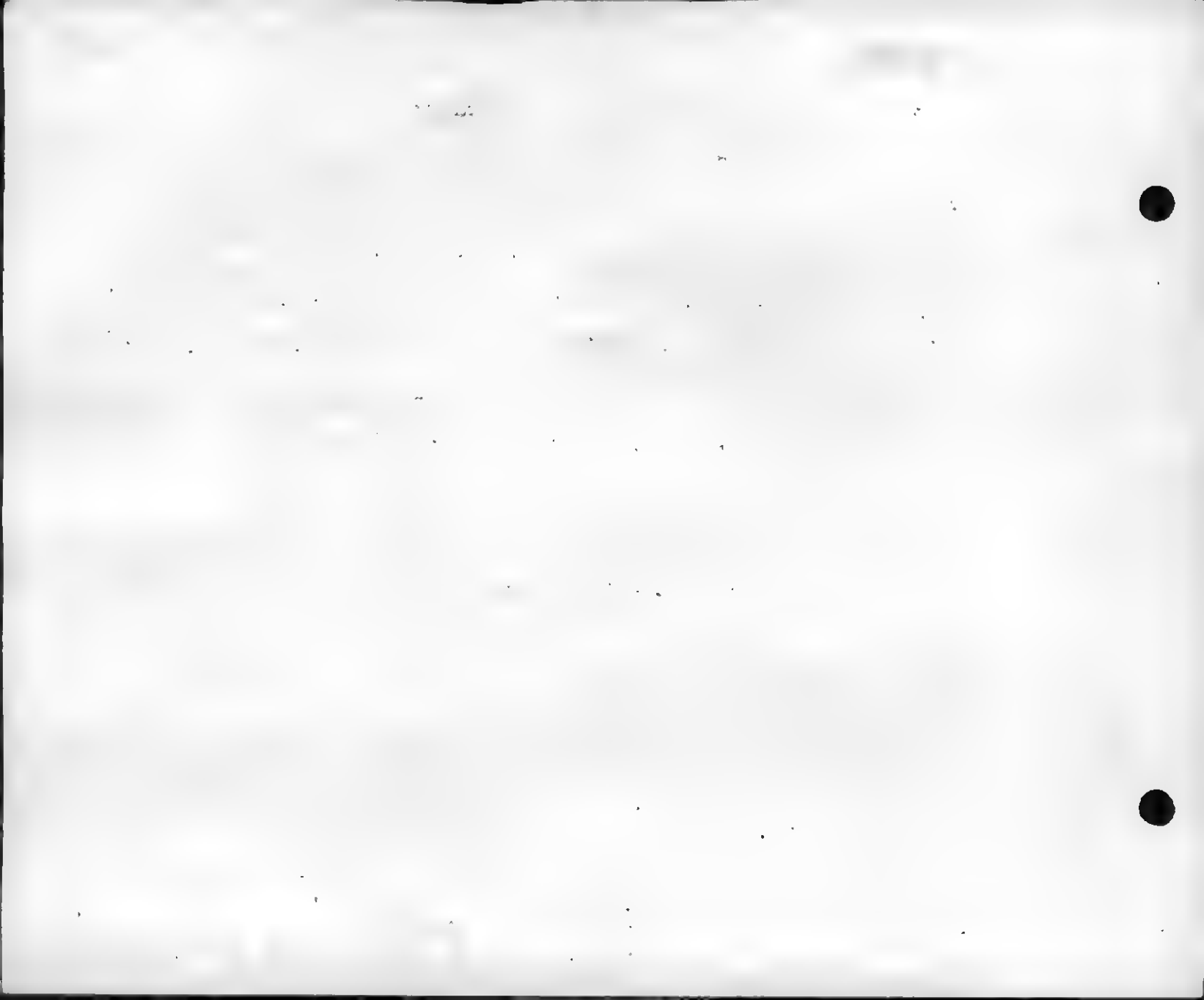
CERTIFICATE OF DEATH

35078

1. DECEASED-NAME (Type or print) / Sherman A. Henson		20. DATE OF DEATH Month 4 Day 16 Year 68 7:50a M	
3 SEX Male	4. RACE Negro	5 DATE OF BIRTH 11/13/99	6 AGE (in years last birthday) 68 YRS.
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel Md
10. CITY OR TOWN OF DEATH Crownsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Unknown	12b. KIND OF BUSINESS OR INDUSTRY
13a US. AL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland	13b COUNTY Anne Arundel	13c CITY OR TOWN Lothian	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last Alexander Henson	15. MOTHER'S MAIDEN NAME First Middle Last Frances Unknown Buden	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No	
16b. SOCIAL SECURITY NO. Unknown		17 INFORMANT Hospital Records, Crownsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary edema severe; Focal Broncho- DUE TO, OR AS A CONSEQUENCE OF pneumonia, RLL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 12/1/68 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Emaciation; ASCVD PTB, inactive IUL			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 8/2, 1961, to 4/16, 1968, that (I) (we) last saw the deceased alive on 4/16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE L. Benedict, M.D.		22c DATE SIGNED 4/16/68	22d. PHYSICIAN'S NAME (Type) L. Benedict, M.D.
22e ADDRESS Crownsville State Hosp. Maryland		22f. PHYSICIAN'S NAME (Type) L. Benedict, M.D.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4-20-1968	23c. NAME OF CEMETERY OR CREMATORY Beechwood	23d. LOCATION (City or Town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR William Reese #	25a REC'D BY REGISTRAR DATE APR 18 1968	25b. REGISTRAR'S SIGNATURE Johnas Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR A.M.		
Walter Edward HERR, Sr.						Month Day Year April 10 1968		3:10 M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR MONTHS DAYS		
Male		white		May 28, 1897		70 YRS				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
W. Va		USA				Anne Arundel Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Annapolis			A. A. Gen Hosp			Inspector		Wid. State P.R.		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md			AR Co		Annapolis		YES		3 Annapolis, Md	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
Walter Osbourn HERR			Lida Rush							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address					
Yes			18-19-20-21		Rosemary Herr 3 Annapolis St Annapolis					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>L. ventricular failure</u>									1 week	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u>									1 week	
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4-21										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State		
22a I certify that (I) (this hospital) attended the deceased from <u>1/16</u> , 19 <u>63</u> , to <u>4/10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/10/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Gen. A. Chappin</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>4/10/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Gen. A. Chappin</u>					22e. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>7-6-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount</u>		23d. LOCATION (City or Town) (County) (State)				
24 FUNERAL DIRECTOR ADDRESS <u>1-3</u>					25a REC'D BY REGISTRAR DATE <u>APR 15 1968</u>		25b REGISTRAR'S SIGNATURE <u>J. J. Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

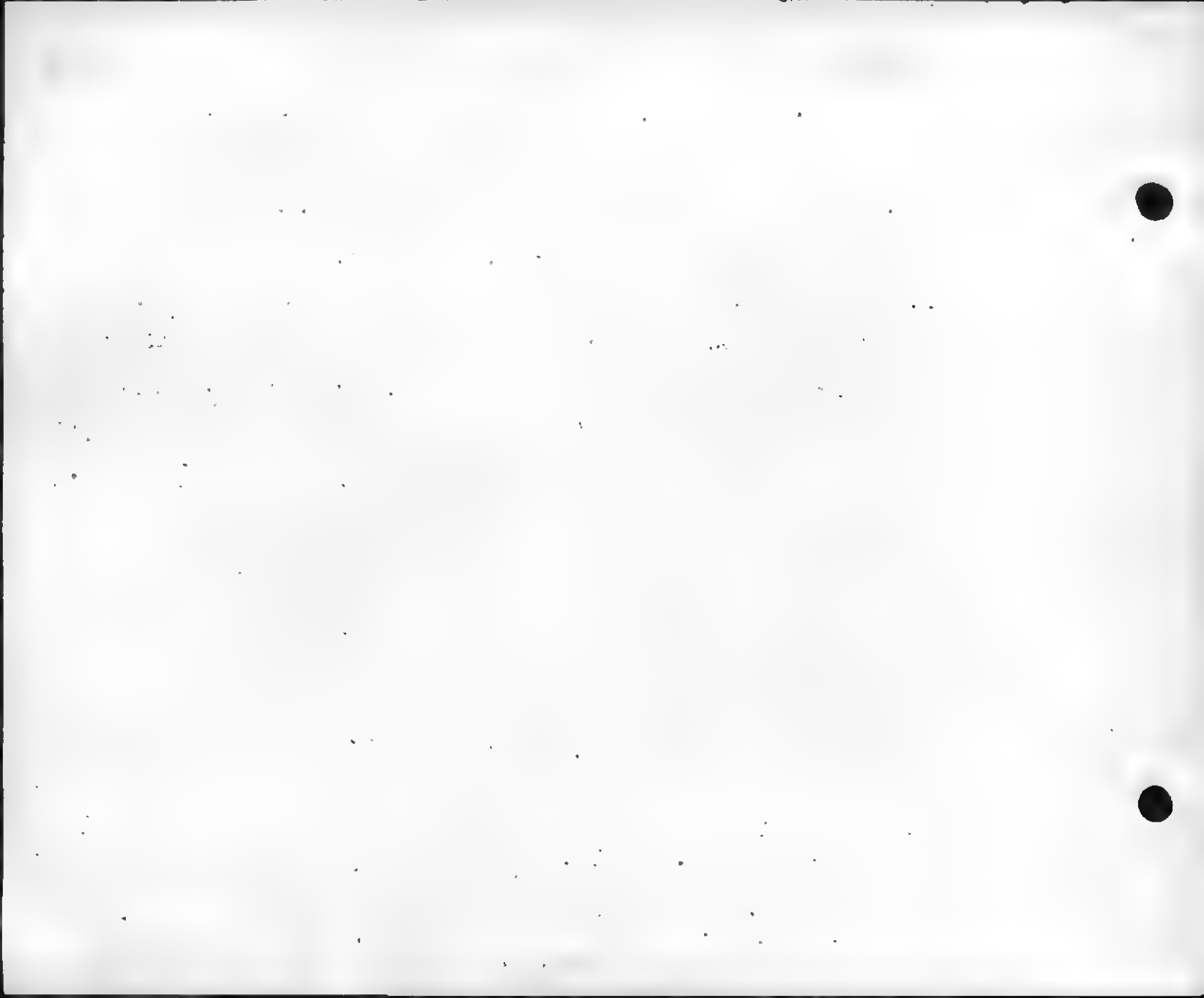
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05280

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Charles E. Hickey			2a. DATE OF DEATH Month Day Year 4- 8- 19 8			2b. HOUR 9:45 PM	
3. SEX male		4. RACE white		5. DATE OF BIRTH 1-20-16		6. AGE (In years last birthday) 52 YRS.	
7a. BIRTHPLACE (State or foreign country) Neb.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A. Md.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Govt.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Odenton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Michael A. Hickey		15. MOTHER'S MAIDEN NAME First Middle Last Mary Friday		13e. STREET AND NUMBER 1307 Odenton Rd. 21113			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Edith F. Hickey -		Address 301 P As # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>general Carcinomatosis</u> 16211 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF (d) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Feb 10</u> <u>April 8</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1635</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from <u>6/15</u> , 19 <u>60</u> , to <u>4/8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/7/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Febe G. G. G. G.</u>				22c. DATE SIGNED 4/9/68		22d. PHYSICIAN'S NAME (Type) Febe G. G. G. G.	
22e. ADDRESS 1113 Odenton Rd Odenton Md		23a. BURIAL, CREMATION, REMOVA. (Specify) Burial		23b. DATE 4/13/68		23c. NAME OF CEMETERY OR CREMATORY Fairbury Cemetery	
23d. LOCATION (City or Town) (County) (State) Fairbury Nebraska		24. FUNERAL DIRECTOR Robert P. Jare Singleton Funeral Home/Glen Burnie, Md.		25a. REC'D BY REGISTRAR APR 11 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR 4-10-68
304M REV 1/68

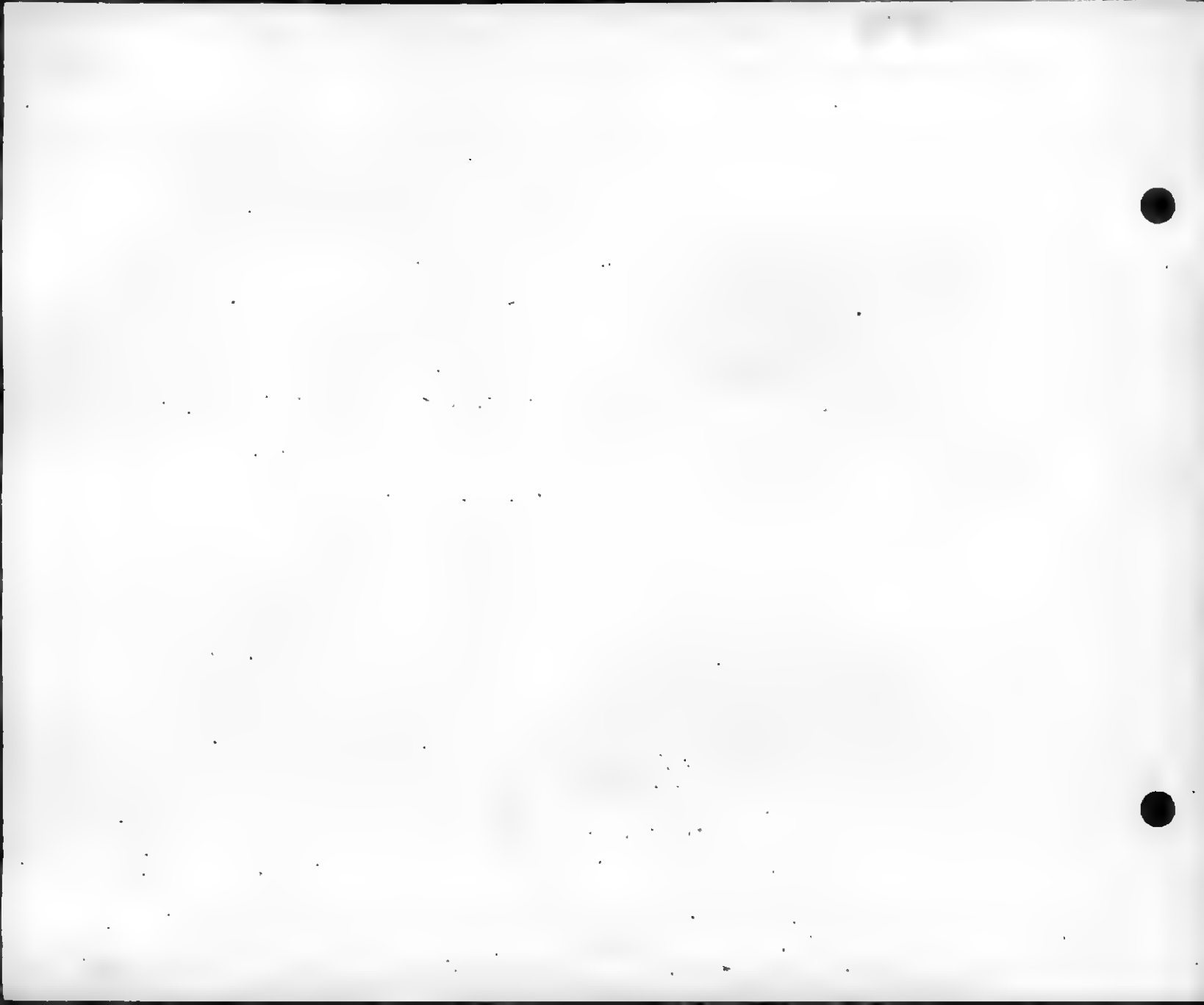
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Form # 33a, c, Film # 2, 00 5/24/68 km

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Hosannah Holloway		2a. DATE OF DEATH Month Day Year 4 29 68		2b. HOUR 3:00 AM
3 SEX F	4 RACE Negro	5. DATE OF BIRTH 3-19-99		6. AGE (In years lost birthday) 69 YRS.
7a. BIRTHPLACE (State or foreign country) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Anne Arundel Md				
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Howard	13c. CITY OR TOWN Hanover	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last ?		15. MOTHER'S MAIDEN NAME First Middle Last ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Barbara Kelgore 217 Race Rd
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 4367 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <u>4/27, 1968</u> to <u>4/29, 1968</u> , that (I) (we) last saw the deceased alive on <u>4/28, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE C. Dorkan MD		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/29/68
22d. PHYSICIAN'S NAME (Type) C. Dorkan MD		22e. ADDRESS 325 Hospital Drive, G. Burnie, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE May 3/68	23c. NAME OF CEMETERY OR CREMATORY St. Auburn		23d. LOCATION (City or Town) (County) (State) Woodport Md.
24. FUNERAL DIRECTOR Miller Election		ADDRESS 1129 N. Central		25a. REC'D BY REGISTRAR MAY 6 1968
				25b. REGISTRAR'S SIGNATURE Charles Judge

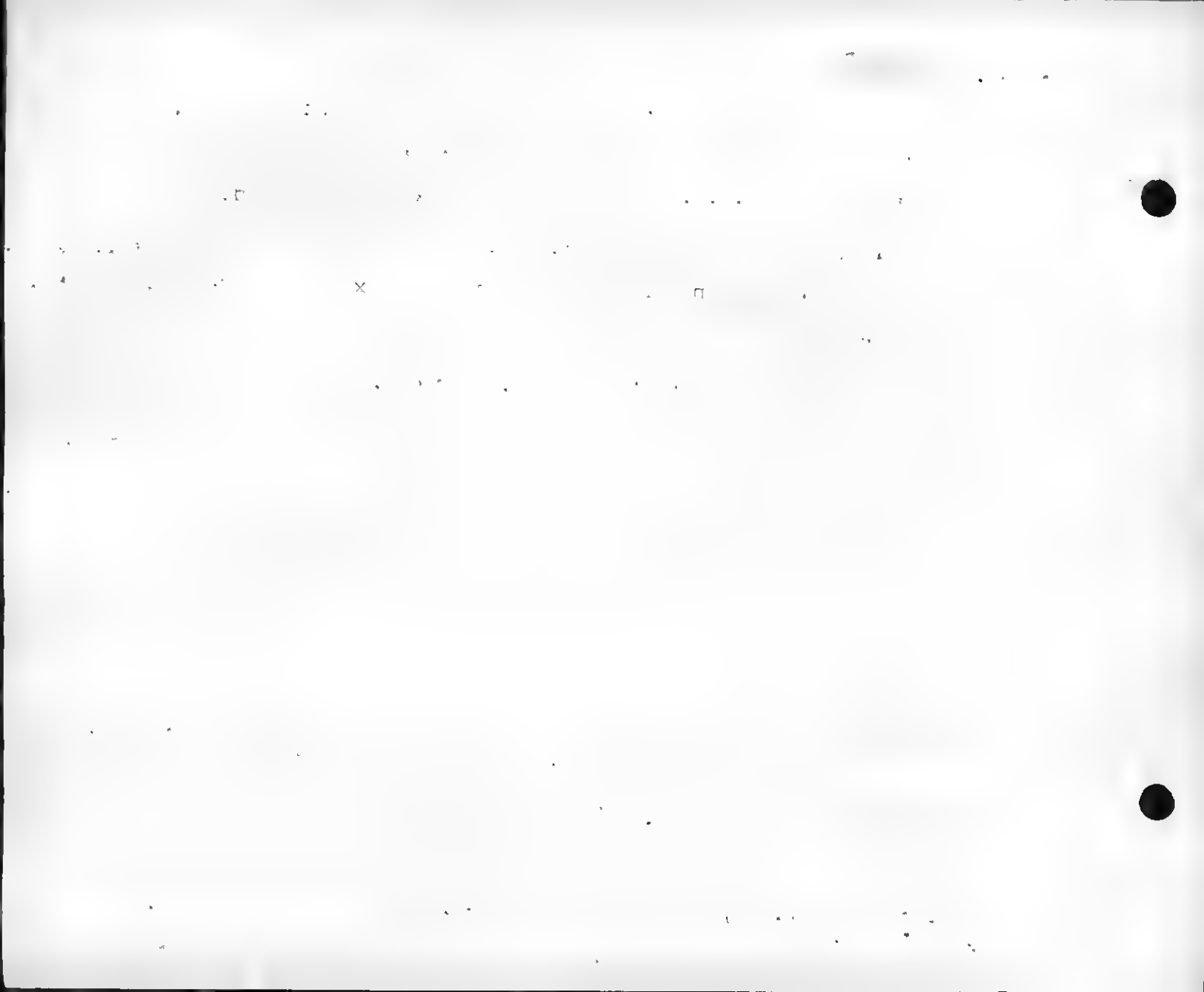


MAY 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) LENA First M. Middle HOOD Last			2a. DATE OF DEATH Month April Day 14 Year 1968			2b. HOUR M		
3 SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 9, 1905		6. AGE (In years last birthday) 62 YRS		
7a. BIRTHPLACE (State or foreign country) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Operator		
12b. KIND OF BUSINESS OR INDUSTRY Plast.			13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Odenton	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Box 438 Laugh Chapel Rd.					
14. FATHER'S NAME First Joseph Middle January Last			15. MOTHER'S MAIDEN NAME First Lurene Middle (unknown) Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give year or dates of service)			16b. SOCIAL SECURITY NO. 220 16 7837		17. INFORMANT Address Mr. George L. Hood (son) Same As #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from ad , 19 46 , to April 14, 1968 , that (I) (we) last saw the deceased alive on April 9 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Edward G. Skerritt MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) Edward G. Skerritt MD				22e. ADDRESS Glenburnie, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Apr. 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.		
24. FUNERAL DIRECTOR R. Singleton		SINGLETON ADDRESS Glen Burnie, Maryland		25a. REC'D BY REG. STRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

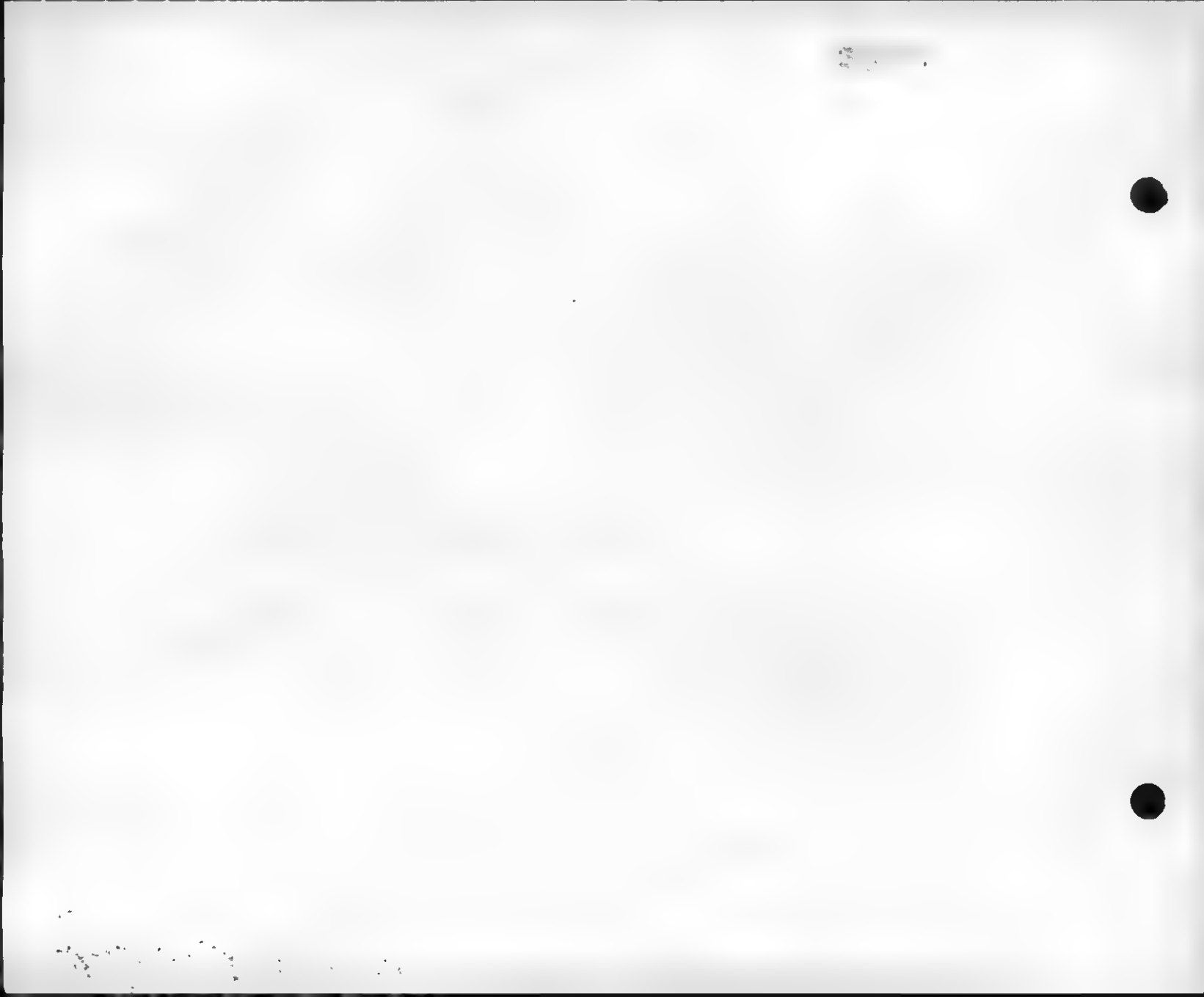


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Walton		First Walton	Middle I	Last HOWARD	2a. DATE OF DEATH Month April Day 10 Year 1968		2b. HOUR 3:00 PM
3 SEX M	4 RACE W	5. DATE OF BIRTH 11-6-1901		6. AGE (In years last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Anne Arundel		Md		
10. CITY OR TOWN OF DEATH Annapolis	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) H.A. GENERAL		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) INSURANCE	12b. KIND OF BUSINESS OR INDUSTRY Auto			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.	13b. COUNTY A.A.	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt #5 Box 14			
14. FATHER'S NAME First William C. Middle Howard Last HOWARD	15 MOTHER'S MAIDEN NAME First Eleanor Middle HARGETT Last HARGETT						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO 214050021	17 INFORMANT NANCY H. Chaffy		Address 1070 Pinecrest Dr. Annapolis, MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Liver Failure, chronic DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertension, chronic DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Thrombosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos 672 hrs 167.2 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Myocardial Infarction							
19a. DATE OF OPERATION 4/3/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Tamponade	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. 19 Month 4 Day 3 Year 1968 P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or RFD No 312 City or Town Annapolis County A.A. State MD					
22a. I certify that (I) (this hospital) attended the deceased from 3/26/68 to 4/9/68 , that (I) (we) last saw the deceased alive on 4/9/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d d) (did not) view the body after death. 3:00 PM 4/10/68							
22b. SIGNATURE J. Fred Hawkins, Jr., MD.		DEGREE MD.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/10/68			
22d. PHYSICIAN'S NAME (Type) J. FRED HAWKINS, JR.		22e. ADDRESS 1611 Pinecrest Dr. Annapolis, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4-13-68	23c. NAME OF CEMETERY OR CREMATORY Hillcrest	23d. LOCATION (City or Town) (County) (State) Annapolis A.A. MD				
24. FUNERAL DIRECTOR John M. Taylor & Sons		ADDRESS Chesapeake, Md.		25a. REC'D BY REGISTRAR DATE APR 16 1968	25b. REGISTRAR'S SIGNATURE John M. Taylor		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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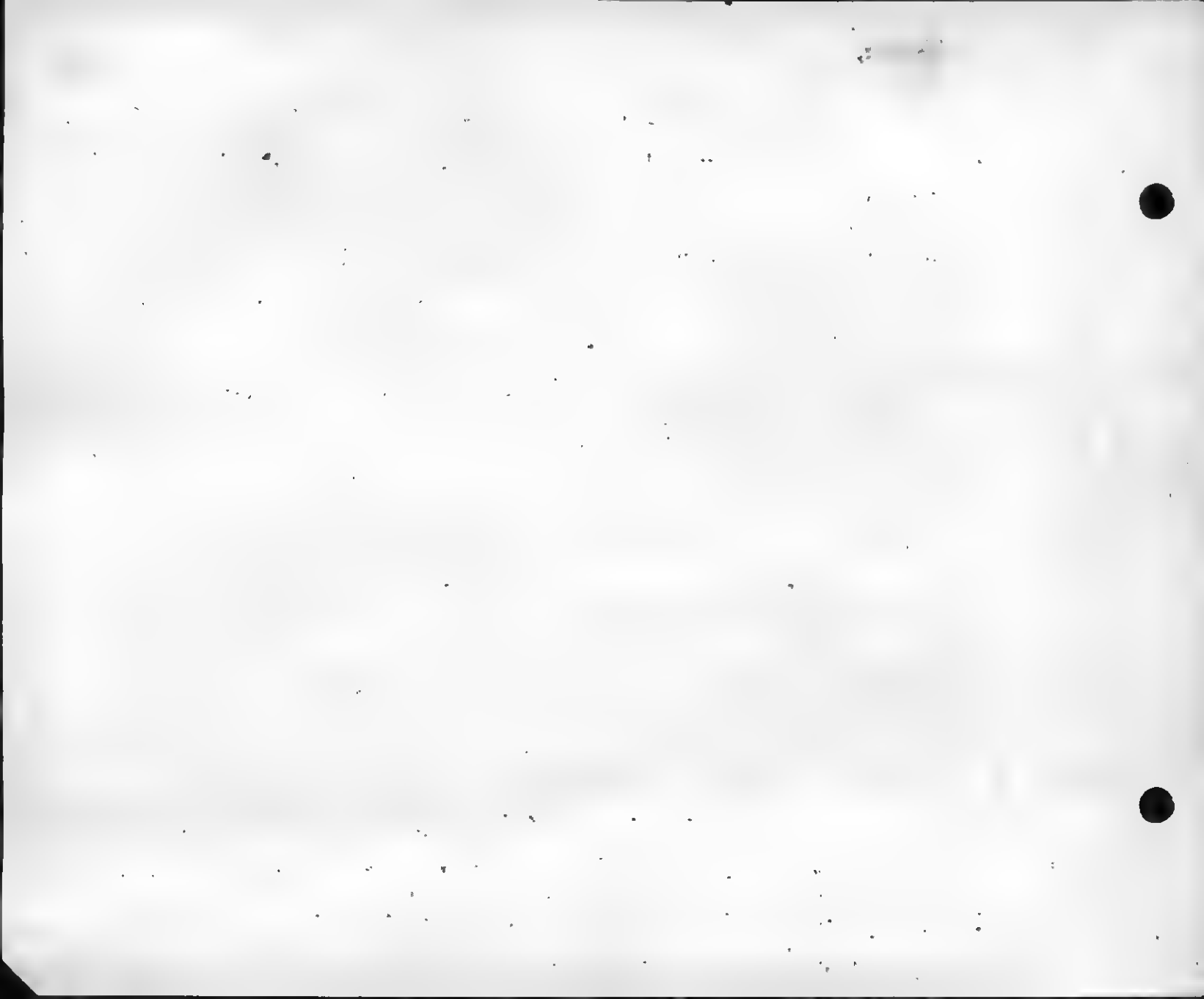
VR A15 (4)
30M REV. 1/68

MD 05084

MD
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

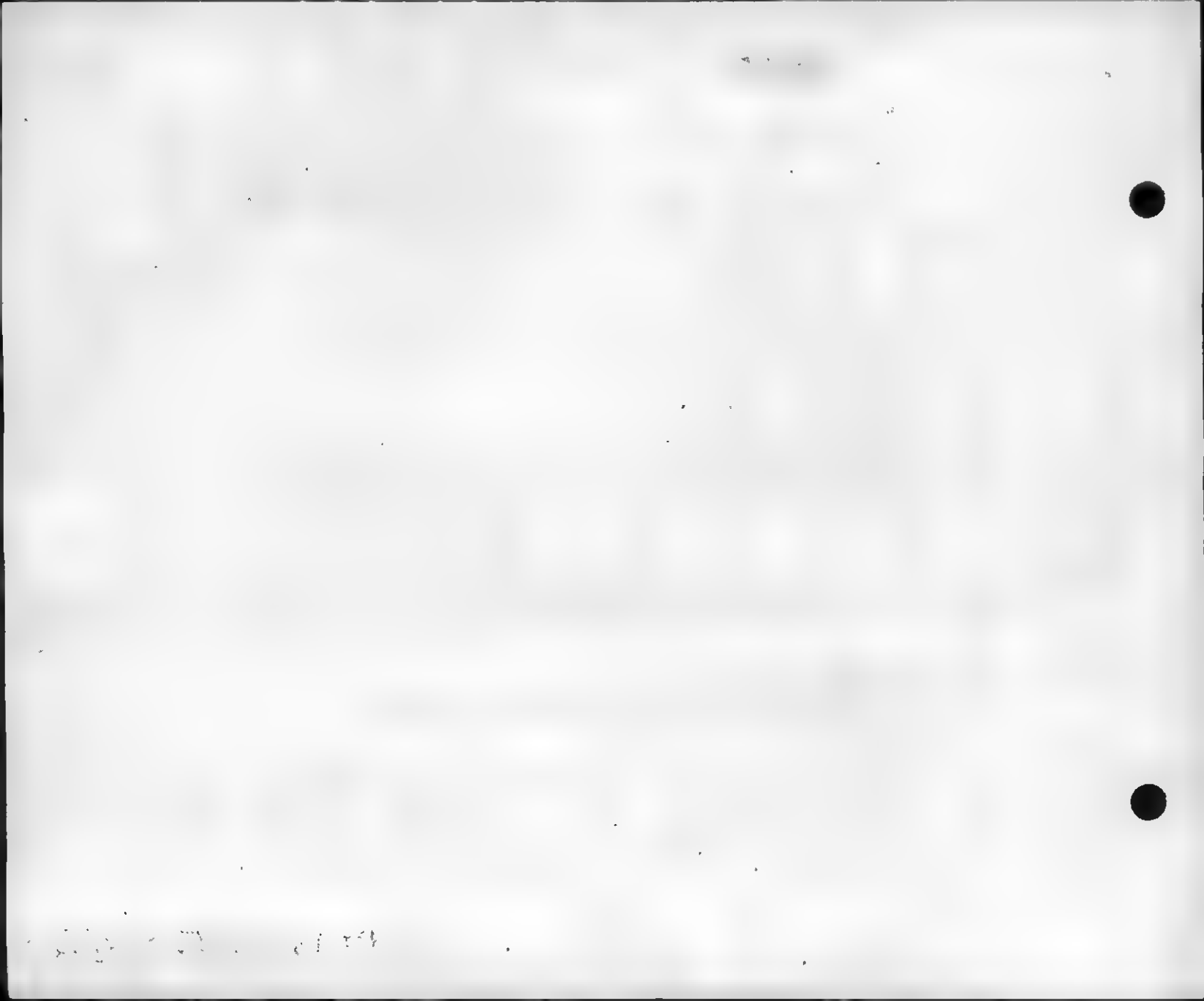
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Elsie Mary Hromadka						Month	Day	Year	5:15 M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Female			White			11/12/03			65 64 YRS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland Unknown			USA						Anne Arundel Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Crownsville			Crownsville State Hosp.			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			-			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
Vincent Kasper			Emma Lavicka			837 N. Collington					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. Unknown			17. INFORMANT			Address		
						Hospital Records, Crownsville State Hosp.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
<u>G U tract infection; /Uremia, Decubitus ulcers; Dehydration and inanition</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/23/68</u> , 19 <u>68</u> , to <u>4/4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
<u>Lionel McHenry Mapp, M.D.</u>						<u>4/4/68</u>					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Lionel McHenry Mapp, M.D.						Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
<u>Burial</u>			<u>April 8, 1968</u>			<u>Holy Redeemer Cemetery</u>			<u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
<u>Philip F. Coach</u>			<u>1211 Chesaco Ave.</u>			<u>APR 8 - 1968</u>			<u>James Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort George, Ga.</u> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>KILBOURN ARMY HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> d. STREET ADDRESS <u>1st Main St. Apt. #4</u> <u>VIRGILIA/1111/1111111111</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>INGLIS, INFANT FEMALE</u>			4. DATE OF DEATH Month Day Year <u>April 13 1968</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>April 13 1968</u>		9. AGE (in years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>0 0 5 45</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>I/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>I/A</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ANNE ARUNDEL, MD</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>INGLIS, FREDERICK G. JR.</u>				
14. MOTHER'S MAIDEN NAME <u>STANLEY</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>0</u> (If yes give war or dates of service)				
16. SOCIAL SECURITY NO. <u>NOIE</u>			17. INFORMANT Address <u>FATHER (Frederick Inglis)</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>IMMEDIATE CAUSE (a) EX-REME PREMATURITY</u> <u>777X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>116X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 13, 1968</u> , to <u>APRIL 13, 1968</u> , that (I) (we) last saw the deceased alive on <u>APRIL 13, 1968</u> , and that death occurred at <u>2115M</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Joseph H. Mearns</u>				22b. DATE SIGNED <u>April 13, 1968</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH H. MEARN MD</u>				22d. ADDRESS <u>ATENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/16/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Vinson Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Summittville, Ind.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Singleton Funeral Home-Glen Burnie, Md.</u> <u>Robert P. Care</u>					
25a. REC'D BY REGISTRAR <u>APR 16 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

BB

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <i>William C. JACKMAN</i>			First Middle Last			2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year <i>4 29 68</i>				2b HOUR <i>10</i> M		
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>11-17-13</i>	6 AGE (in years not birthday) <i>54</i> YRS	F UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD Month <i>4</i> Day <i>29</i> Year <i>68</i>				2d HOUR <i>10</i> M
7a BIRTHPLACE (State or foreign country) <i>D.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>P.A.CO.</i> Md						
10 CITY OR TOWN OF DEATH <i>Annapolis.</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Do A - Home Products Co.</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Distributor</i>				12b KIND OF BUSINESS OR INDUSTRY <i>Beverage</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>			13b COUNTY <i>PG</i>		13c CITY OR TOWN <i>Capt. Hgts.</i>		13d INSIDE CITY (M.T.S?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>6136 Shadyside Ave</i>			
14 FATHER'S NAME First <i>Paul</i> Middle <i>Jackman</i> Last			15 MOTHER'S MAIDEN NAME First <i>Sarah</i> Middle <i>Dove</i> Last									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>			16b SOCIAL SECURITY NO <i>1945-46</i>		17 INFORMANT ADDRESS <i>Thelma E. Jackman (wife) same as #13</i>							
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <i>4299</i> IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>f. d. d.</i>												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year <i>19</i> HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County	State	
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>E. L. H. H.</i>			EXAMINER'S NAME (Type) <i>E. L. H. H.</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED <i>4. 29. 68</i>			
23a BURIAL A. CREMATION, REMOVAL (Specify) <i>Burial</i>			23b DATE <i>5-2-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>			23d LOCATION (City or Town) (County) (State) <i>Suitland Rd. PG Md.</i>				
24 FUNERAL DIRECTOR <i>Wilhelm Funeral Home</i> ADDRESS <i>4308 Suitland Rd SE, Suitland, Maryland</i>						25a REC'D BY REGISTRAR <i>MAY 6 1968</i>		25b REGISTRAR'S SIGNATURE <i>John J. Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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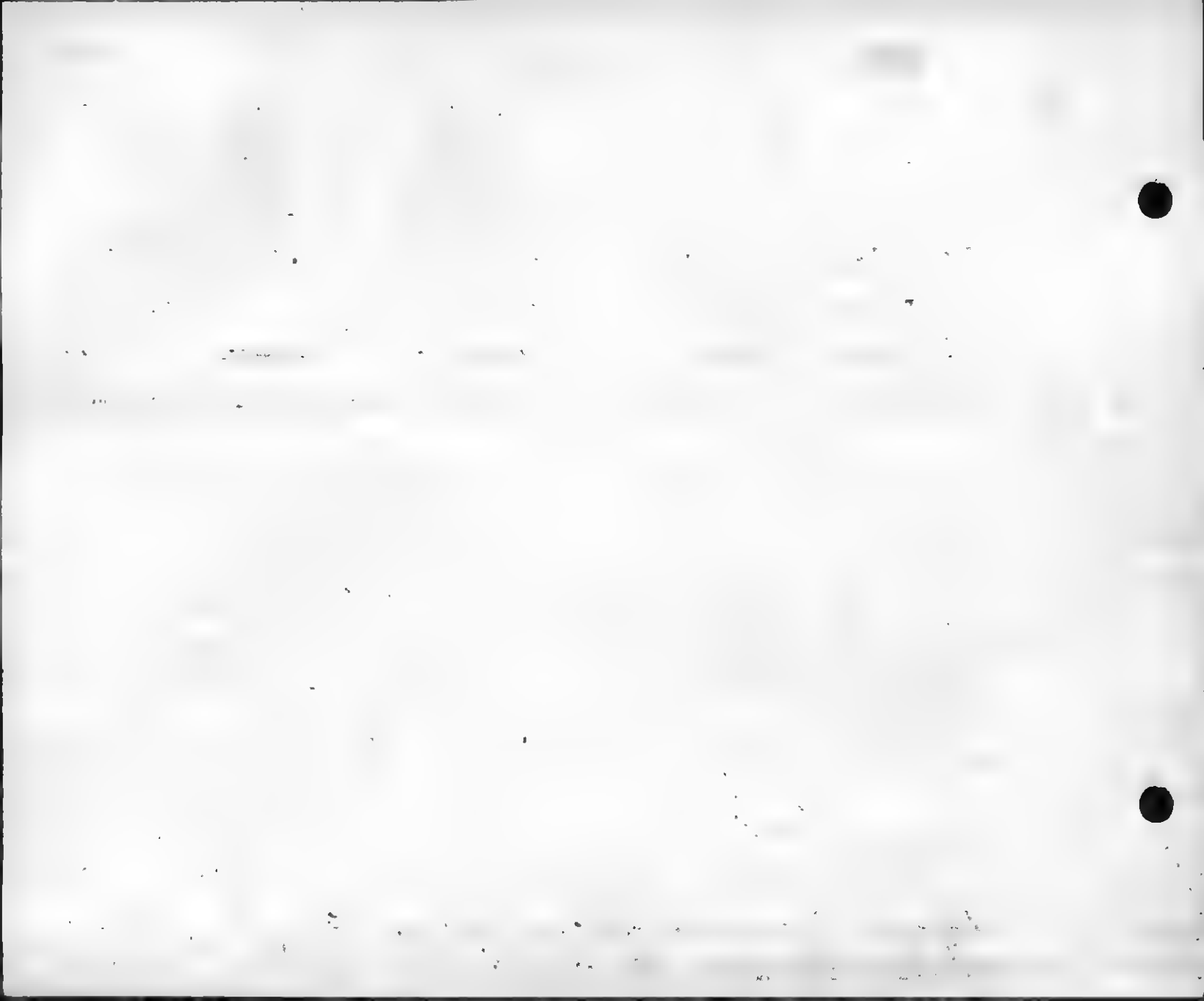
VR A1574
30M REV. 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1968

1. DECEASED-NAME (Type or print) First Middle Last James C. Jacobs			2a. DATE OF DEATH Month Day Year 4 18 68			2b. HOUR 11:00aM			
3 SEX Male		4. RACE White		5. DATE OF BIRTH 5/18/83		6. AGE (In years lost birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md			
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Unknown FARMER		12b. KIND OF BUSINESS OR INDUSTRY FARM			
13a. USUAL RESIDENCE (Where deceased lived, if instituton: Residence before admission) STATE Maryland		13b. COUNTY AA		13c. CITY OR TOWN Severn Md		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Jacobs Rd. Severn, Md.	
14. FATHER'S NAME First Middle Last GEORGE L. JACOBS			15. MOTHER'S MAIDEN NAME First Middle Last REBECCA DONALDSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Unknown		16b. SOCIAL SECURITY NO. 218-36-7514		17. INFORMANT Hospital Records, Crownsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4127 DUE TO, OR AS A CONSEQUENCE OF (b) ASHD DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Uremia, Bilateral Inguinal Hernia, Schizophrenia, Cachexia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from 5/27, 1968, to 4/18, 1968, that (1) (we) last saw the deceased alive on 4/18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L. Benedict, M.D.								22c. DATE SIGNED 4/18/68	
22d. PHYSICIAN'S NAME (Type) L. Benedict, M.D.								22e. ADDRESS Crownsville State Hospital, Maryland	
23a. B. RIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-20-68		23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		23d. LOCATION (City or Town) (County) (State) Cheston Md.			
24. FUNERAL DIRECTOR Dr. Will Darnedean, Rural, Md				25a. RECD BY REGISTRAR DATE APR 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First MABEL Middle R. Last JEWELL		2a. DATE OF DEATH April Month 8 Day 1968		2b. HOUR 2:A.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH Jan. 1884	
6 AGE (In years last birthday) 84 YRS		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH Anne Arundel Md					
10 CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) City of Pasadena Beach Road		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Unemployed	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia		13b COUNTY Roanoke		13c CITY OR TOWN Roanoke	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2311 Organe Ave. N/W			
14 FATHER'S NAME First Middle Last Dave Creasy			15. MOTHER'S MAIDEN NAME First Middle Last Betty Hall		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input type="checkbox"/> -----		16b. SOCIAL SECURITY NO. 225-64-6215		17 INFORMANT Address William Jewell - Same as # 13	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary arteriosclerotic heart disease 4127 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Thrombosis (c) _____ (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 2 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____	
22a. I certify that (I) (this hospital) attended the deceased from March 1, 1968 to April 8, 1968 , that (I) (we) last saw the deceased alive on April 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R.M. McLaughlin		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/8/68	
22d. PHYSICIAN'S NAME (Type) R.M. McLaughlin		22e. ADDRESS 3708 Mountain Rd. Pasadena, Md			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 10/Apr. 1968		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	
23d. LOCATION (City or Town) Roanoke, Va.		(County) _____ (State) _____			
24. FUNERAL DIRECTOR R.V. Singleton - Glen Burnie, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 9 - 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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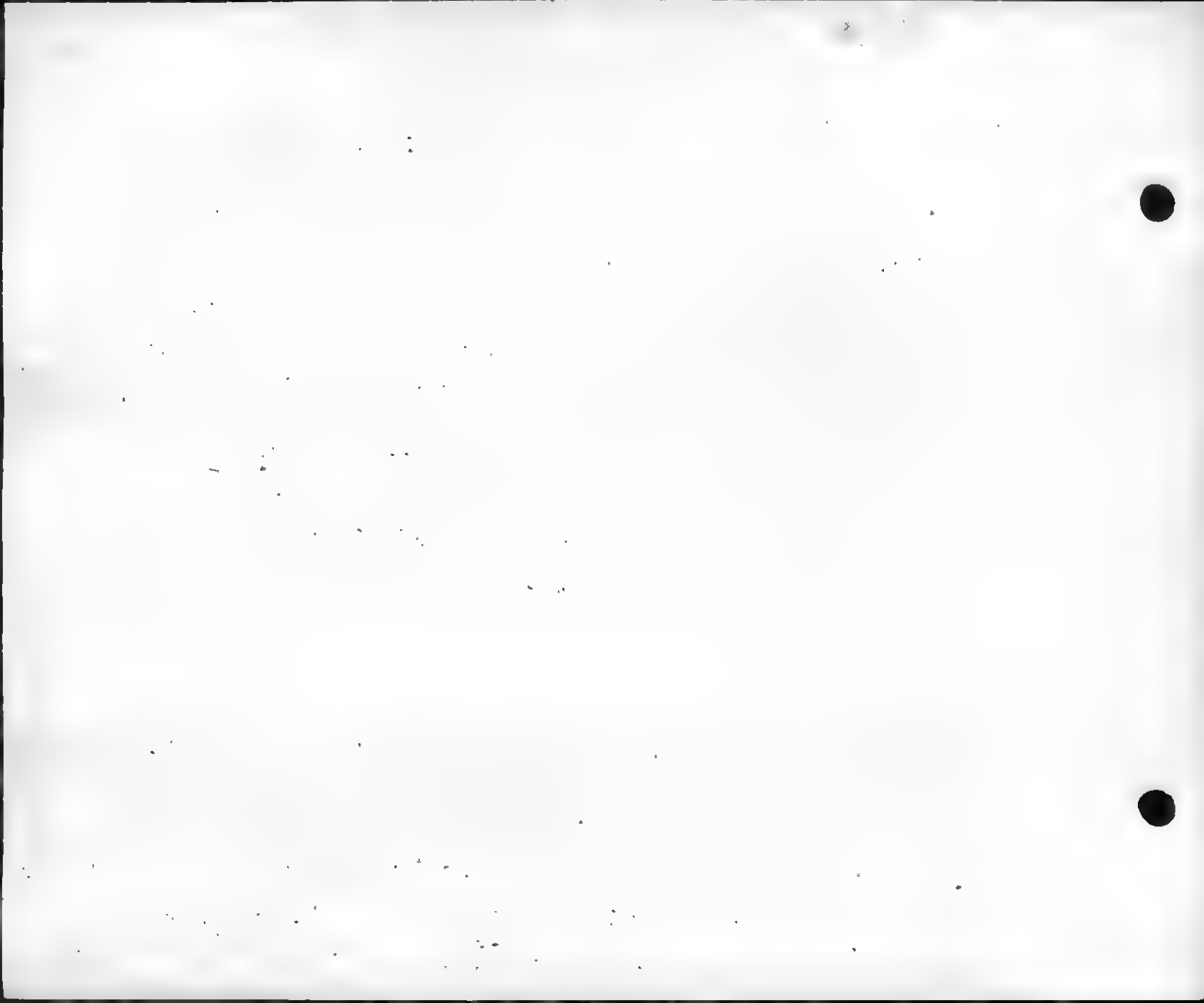


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VR 4-5 (7-6)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b HOUR	
Arthur		A.		Jones				Month 4 Day 11 Year 68		10:15 AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years lost birthday)		7 YEARS		8 MONTHS	
Male		Negro		3-28-01		67 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.				Anne Arundel				Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Glen Burnie		North Arundel Hospital		Laborer							
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM TS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Anne Arundel		Baltimore				115 Key Ave.			
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
John E. Jones								Sarah E. Chew			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address					
Yes, no, or unknown		218-03-4634		Calvin Gorman		Huntingtown, Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
41m				Cerebrovascular Heart Disease		(b) Generalized Atherosclerosis					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						(c) Hypertension Diabetes mellitus					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		42002d. Heavy Legia. Uremia									
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20d. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 2/29/1968, to 4/14/1968, that (I) (we) last saw the deceased alive on 4/12/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		O. Dorkan, MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		4/14/68	
22d. PHYSICIAN'S NAME (Type)		O. Dorkan, MD.				22e. ADDRESS		325 Hospital Drive, #104, Glen Burnie, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
4-15-68		4-15-68		Saturated Church Lane		Huntingtown Md.					
24. FUNERAL DIRECTOR		ADDRESS		M.D. NO. REC'D BY REGISTRAR		25. REGISTRAR'S SIGNATURE					
Leroy E. Berry		Huntingtown, Md.		DATE		APR 22 1968		Charles Judge			



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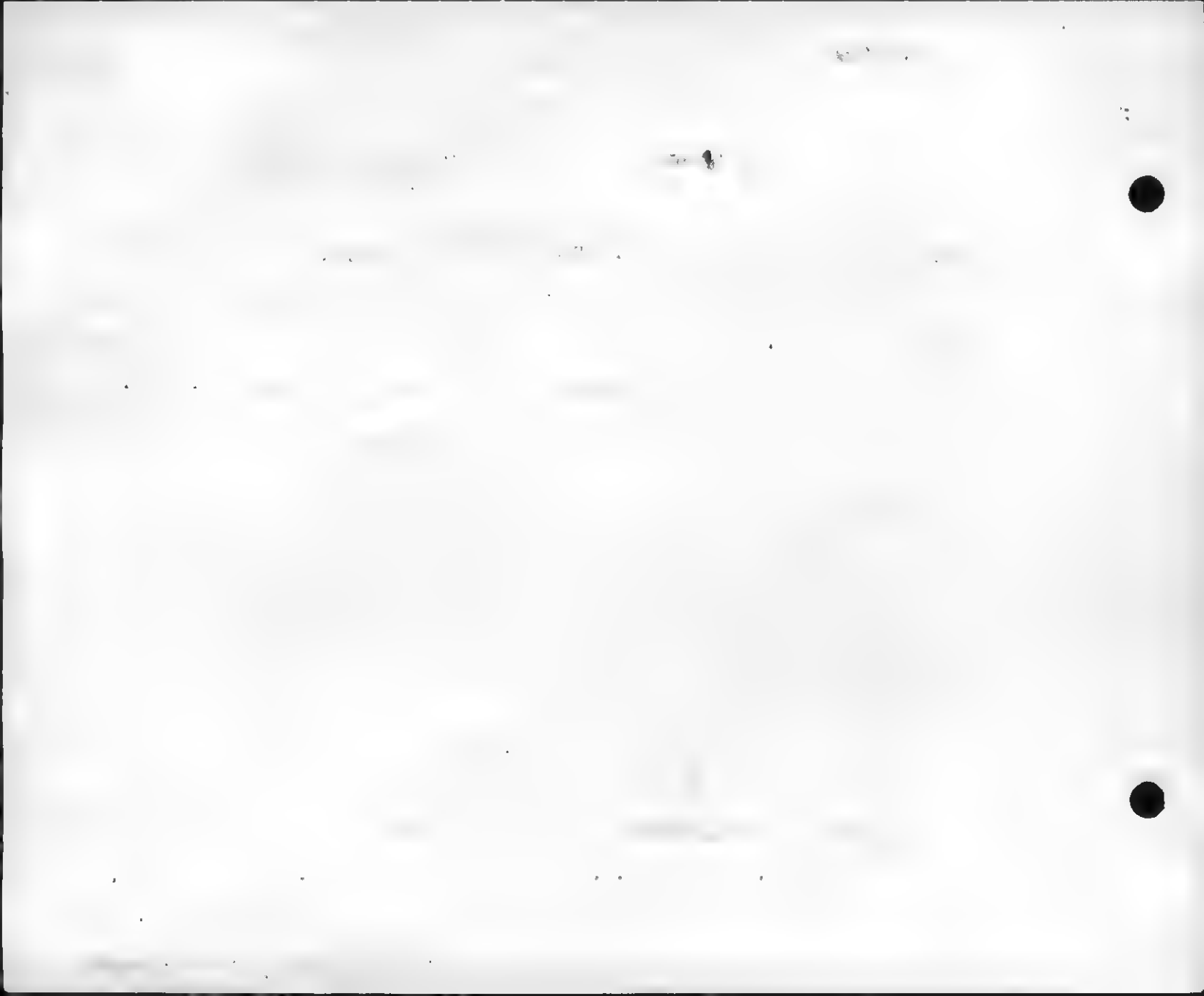
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05-00

Item 11 Film G400
Item 13 Film G400

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Lucy (none) JONES			2a DATE OF DEATH Month Day Year April 28 1968			2b HOUR A.M. 6:50 M				
3 SEX Female		4 RACE Colored		5 DATE OF BIRTH 8-? 1893		6 AGE (in years last birthday) 74 YRS.		F UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Maryland,		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital Domestic		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		3d. INHABITANT CITY, JIM TSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7 Murray Avenue		
14 FATHER'S NAME First Middle Last James A. Jones			15 MOTHER'S M.A.D.E.N. NAME First Middle Last Sarah Gambrill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) [yes give war or dates of service]		16b. SOCIAL SECURITY NO 219-54-4279		17 INFORMANT Daisy Mackall Dunkirk, Md.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THYROID 195X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 4/19/ 1968 , to 4/28/ 1968 , that (I) (we) last saw the deceased alive on 4/27/ 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE Jesse L. Wilkins		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/29/68				
22d. PHYSICIAN'S NAME (Type) Jesse L. Wilkins, M.D.		22e. ADDRESS 98 Cathedral St., Annapolis, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-3-68		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Carters Ch.Cem		23d. LOCATION (City or Town) (County) (State) Friendship AA. Md				
24. FUNERAL DIRECTOR Prattney E. Sawell Prince Fred, Md.		ADDRESS		25a. REC'D BY REGISTRAR MAY 3 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge				



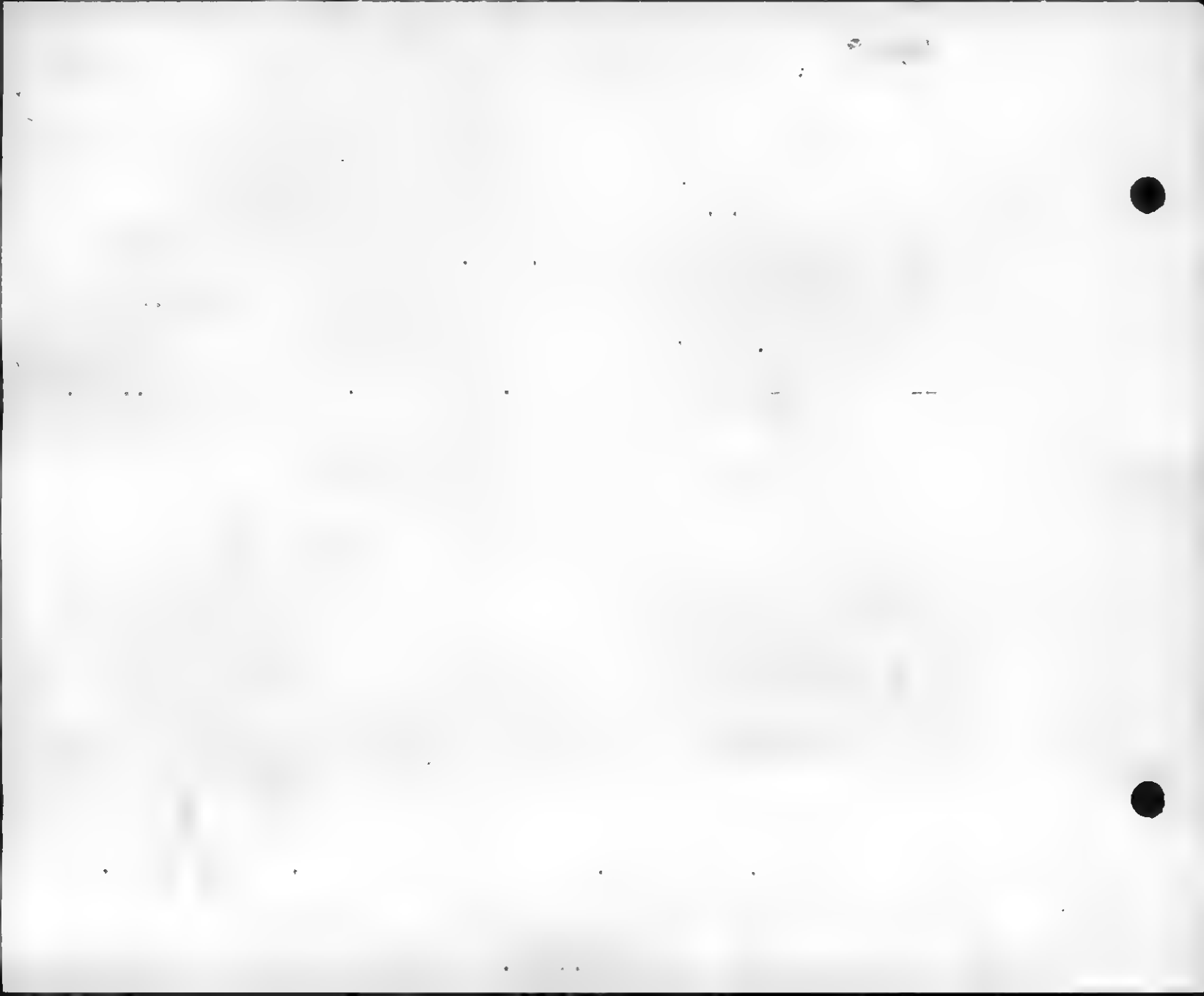
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MD 15-10
304M REV. 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Margaret Gladys JONES			2a. DATE OF DEATH Month April Day 3 Year 1968			2b. HOUR 7:25 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 22, 1902		6. AGE (In years lost birthday) 65 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 19 Brewer Ave.,		14. FATHER'S NAME First Middle Last William C. Smith		15. MOTHER'S MAIDEN NAME First Middle Last Alice Jane Smith		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> no <input checked="" type="checkbox"/> at unknown <input type="checkbox"/>	
16b. SOCIAL SECURITY NO. ---		17. INFORMANT Mr. Bernard A. Jones		Address 19 Brewer Ave Anna., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic ovarian carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 mos.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1750</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>68</u> , to <u>April 3</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>April 3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Barber C. Palmer, M.D.</u>				22c. DATE SIGNED <u>4-4-68</u>		22d. PHYSICIAN'S NAME (Type) Barber C. Palmer, M.D.	
22e. ADDRESS 121 Cathedral St., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 6 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cem		23d. LOCATION (City or Town) (County) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR Beall Funeral Home				24a. ADDRESS 1212 West St Anna., Md.		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE APR 9 - 1968				REC'D BY REG STRAR			



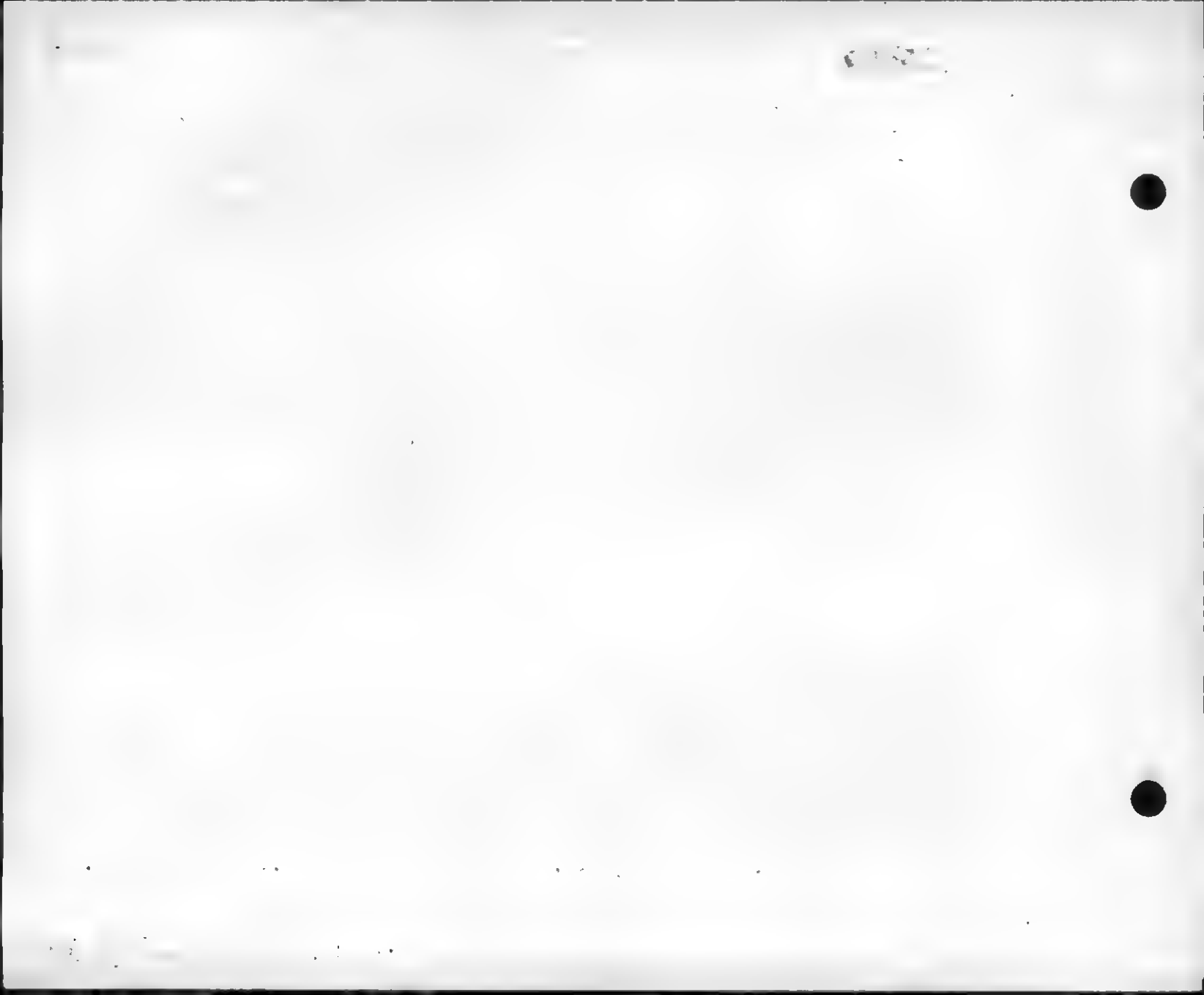
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

It is the law of the State of Maryland that the death certificate be executed within 24 hours after death.
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Spencer J. JONES			2a. DATE OF DEATH Month Day Year April 9 1968			2b. HOUR 4 ^{PM}	
3 SEX M		4 RACE W		5 DATE OF BIRTH 8-10-1897		6 AGE (in years last birthday) 70 YRS	
7a BIRTH-PLACE (State or foreign country) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Anne Arundel Md	
10. CITY OR TOWN OF DEATH Annapolis		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A.H. GENERAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CIVIL SERVICE		12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a U.S.A. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MD.		13b COUNTY A.H.		13c CITY OR TOWN Bay Ridge		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER 18 Hull Ave.		14 FATHER'S NAME First Middle Last SAMUEL JONES		15 MOTHER'S M.A.DEN NAME First Middle Last GERTRUDE CHEW			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) YES WWI		16b SOCIAL SECURITY NO		17 INFORMANT FANNIE M. JONES		Address #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dist. gastro-intestinal infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>(functional)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause as:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a DATE OF OPERATION April 5 68		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21b TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>April 5</u> , 19 <u>68</u> , to <u>April 9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>April 9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Stephen B. Hiltabidle</u>		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>April 10 68</u>	
22d. PHYSICIAN'S NAME (Type) Stephen B. Hiltabidle, M.D.		22e ADDRESS 121 Cathedral St., Annapolis, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 4-12-68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) (County) (State) Annapolis A.H. MD	
24. FUNERAL DIRECTOR <u>John M. Lythgoe</u>		ADDRESS Annapolis, Md.		25a REC'D BY REGISTRAR DATE APR 16 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05093

05097

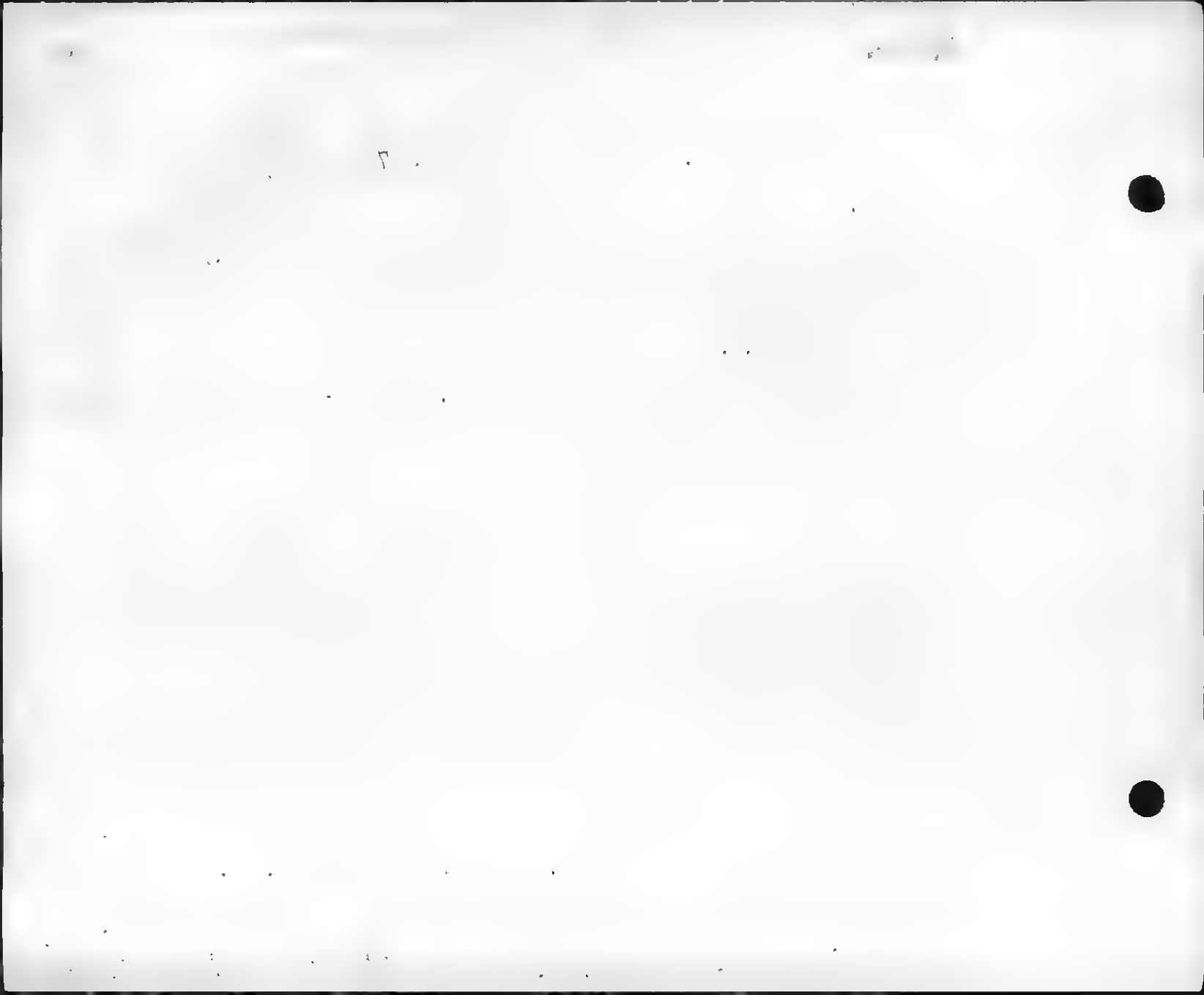
1. DECEASED-NAME (Type or print) First Middle Last CLAUDE J. KATZ			2a. DATE OF DEATH Month Day Year April 21, 1968			2b. HOUR 6:10A-M	
3 SEX Male		4 RACE white		5. DATE OF BIRTH July 5, 1892		6. AGE (In years last birthday) 75 YRS	
7a BIRTHPLACE (State or foreign country) Florida		7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Anne Arundel Md	
10 CITY OR TOWN OF DEATH Millersville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Knollwood Manor Nursing H		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b KIND OF BUSINESS OR INDUSTRY Cook	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Glen Burnie		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 207 King George Drive	
14 FATHER'S NAME First Middle Last Julis Katz			15. MOTHER'S MAIDEN NAME First Middle Last Rosa (unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) yes		16b. SOCIAL SECURITY NO. 068-10-2515		17. INFORMANT Address Gloria Milliken (daughter) Same as # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Septicemia</u> 454.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cellulitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Varicose Veins</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Generalized arteriosclerosis</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (i) (this hospital) attended the deceased from <u>4/9, 1968</u> to <u>4/21, 1968</u> ; that (i) (we) last saw the deceased alive on <u>4/9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did not) view the body after death.							
22b SIGNATURE Richard I. Hochman, MD				22c. DATE SIGNED 4/21/68			
22d PHYSICIAN'S NAME (Type) Richard I. Hochman, MD				22e ADDRESS 16 Murray Ave, Annapolis, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/24/68		23c NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d LOCATION (City or Town) (County) (State) Stanton Island N.Y.	
24 FUNERAL DIRECTOR E. B. Thompson		ADDRESS Singleton Funeral Home		24a REC'D BY REGISTRAR Charles Judge		24b REGISTRAR'S SIGNATURE Charles Judge	
DATE APR 23 1968							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
Thomas D Keim						Month Day Year April 30 1968			3:00 PM					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
male		Caus.		July 4, 1879			88 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Penna.			USA						Anne Arundel			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Rt 3 Box 367 Harness Creek						draftsman (ret.)			US Gov't		
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Anne Arundel			Annapolis			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 3 Box 367			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
Joseph D.B. Keim			Lilias Gallaher Paxson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
no			none			Lilias K. Stevens - Harness Creek, Annapolis, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Cerebral occlusion.</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(b) <u>Generalized arteriosclerosis.</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c) <u>Stroke.</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
			HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION			Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>Apr. 22</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED					
<u>Roberto DeVillarreal</u>									April 30, 1968					
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS											
Roberto DeVillarreal, MD.			St. Leonards, Cal. Co., Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Cremation			5/2/68			Ft. Lincoln Crematory			Washington D.C.					
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Beverly E. Hopping - <u>Beverly E. Hopping</u>			DATE			MAY 2 1968			<u>Charles Judge</u>					
Hopping Funeral Home - Annapolis, Md.														

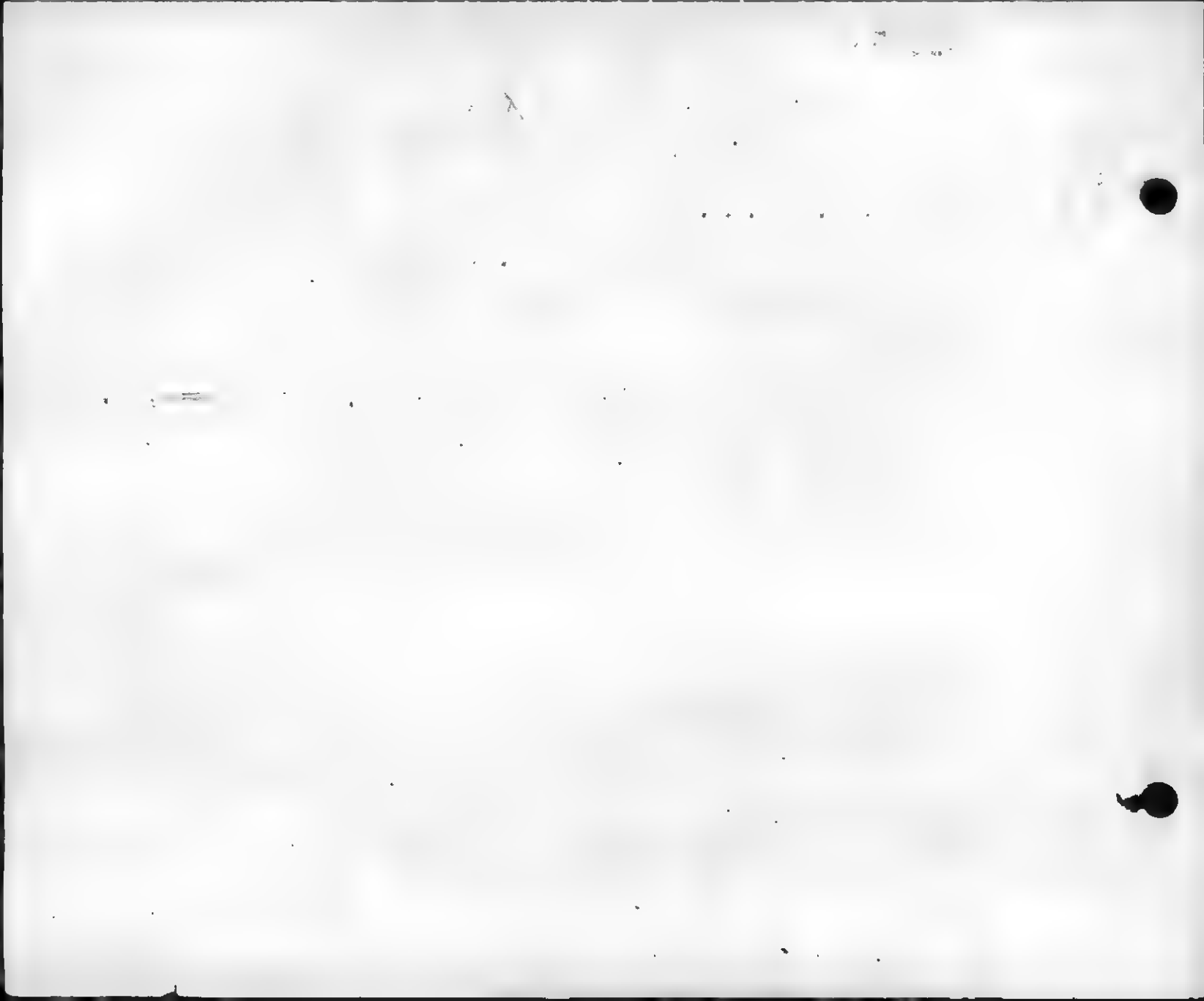


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the examiner should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with forms PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) <i>Joseph Henry Kelt</i>			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>4</i> Day <i>12</i> Year <i>1968</i>			2b HOUR <i>7</i> P M			
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>NOV 3 1901</i>	6 AGE (In years last birthday) <i>66</i> YRS	7 UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	8 IF UNDER 24 HRS HOURS <i></i> M N <i></i>	2c DATE PRONOUNCED DEAD Month <i>4</i> Day <i>12</i> Year <i>1968</i>		2d HOUR <i>7</i> P M	
7a BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>AA. CO.</i>			
10 CITY OR TOWN OF DEATH <i>GREENHAVEN</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>7979 Catherine Ave. Pasadena</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>MACHINEST</i>		12b KIND OF BUSINESS OR INDUSTRY <i>RAILROAD</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE <i>MD</i>		13b COUNTY <i>AA CO</i>		13c CITY OR TOWN <i>PASADENA</i>		13d DISTRICT CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>CATHERINE AVE</i>	
14 FATHER'S NAME First <i>JULIUS KEIM</i> Middle <i></i> Last <i></i>				15 MOTHER'S MAIDEN NAME First <i>CHRISTINA</i> Middle <i>BOLLINGER</i> Last <i></i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16b SOCIAL SECURITY NO. <i>XXXXXX</i>		17. INFORMANT ADDRESS <i>SEVERN EDWARD MOUNT RT. 3 Box 216 Fort Ave., Md.</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))									
PART I DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <i>Cardiac failure</i>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <i>4299</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <i></i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day Year HOUR A.M. <i>19</i> P.M. <i></i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No		City or Town		County	State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. Linhardt</i>		EXAMINER'S NAME (Type) <i>E. Linhardt</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ADDRESS (Street, city, town, or county) <i>AA CO.</i>		22b. DATE SIGNED <i>4/12/68</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b DATE <i>4/15/68</i>		23c NAME OF CEMETERY OR CREMATORY <i>GREEN HAVEN Cem.</i>		23d LOCATION (City or Town) <i>AA</i>		(County) <i>MD</i> (State) <i></i>	
24 FUNERAL DIRECTOR <i>McCully</i>		ADDRESS <i>1301 Fort Ave. Baltimore</i>		25a REC'D BY REGISTRAR <i>APR 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-54)
30M REV 1/68

05096

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Willie M. Kilgore			2a DATE OF DEATH Month Day Year April 26, 1968		2b HOUR 5:22AM
3 SEX Female	4. RACE Negro	5. DATE OF BIRTH 07-01-98		6 AGE (In years last birthday) 70 YRS.	
7a BIRTHPLACE (State or foreign country) South Carolina		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Anne Arundel Co., Md.					
10 CITY OR TOWN OF DEATH Glen Burnie, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Anne Arundel		13c CITY OR TOWN Hanover	
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 217 Race Road		12b KIND OF BUSINESS OR INDUSTRY	
14. FATHER'S NAME First Middle Last Jack Byrd			15. MOTHER'S MAIDEN NAME First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Barbara Kilgore Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4000 DUE TO, OR AS A CONSEQUENCE OF (b) Nephrosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) HTS X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3/16 , 19 68 , to 4/20 , 19 68 , that (I) (we) last saw the deceased alive on 4/16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alejandro Montoya		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d PHYSICIAN'S NAME (Type) Dr. Alejandro Montoya		22e ADDRESS 707 Old Annapolis Rd., Glen Burnie			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE May 1/68		23c NAME OF CEMETERY OR CREMATORY Brook Natl Cem.	
23d LOCATION (City or Town) (County) (State) 5501 Frederick Ave					
24. FUNERAL DIRECTOR Donald E. Erickson		ADDRESS 11297 N. Carlisle St		25a. REC'D BY REGISTRAR DATE MAY 6 1968	
25b REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

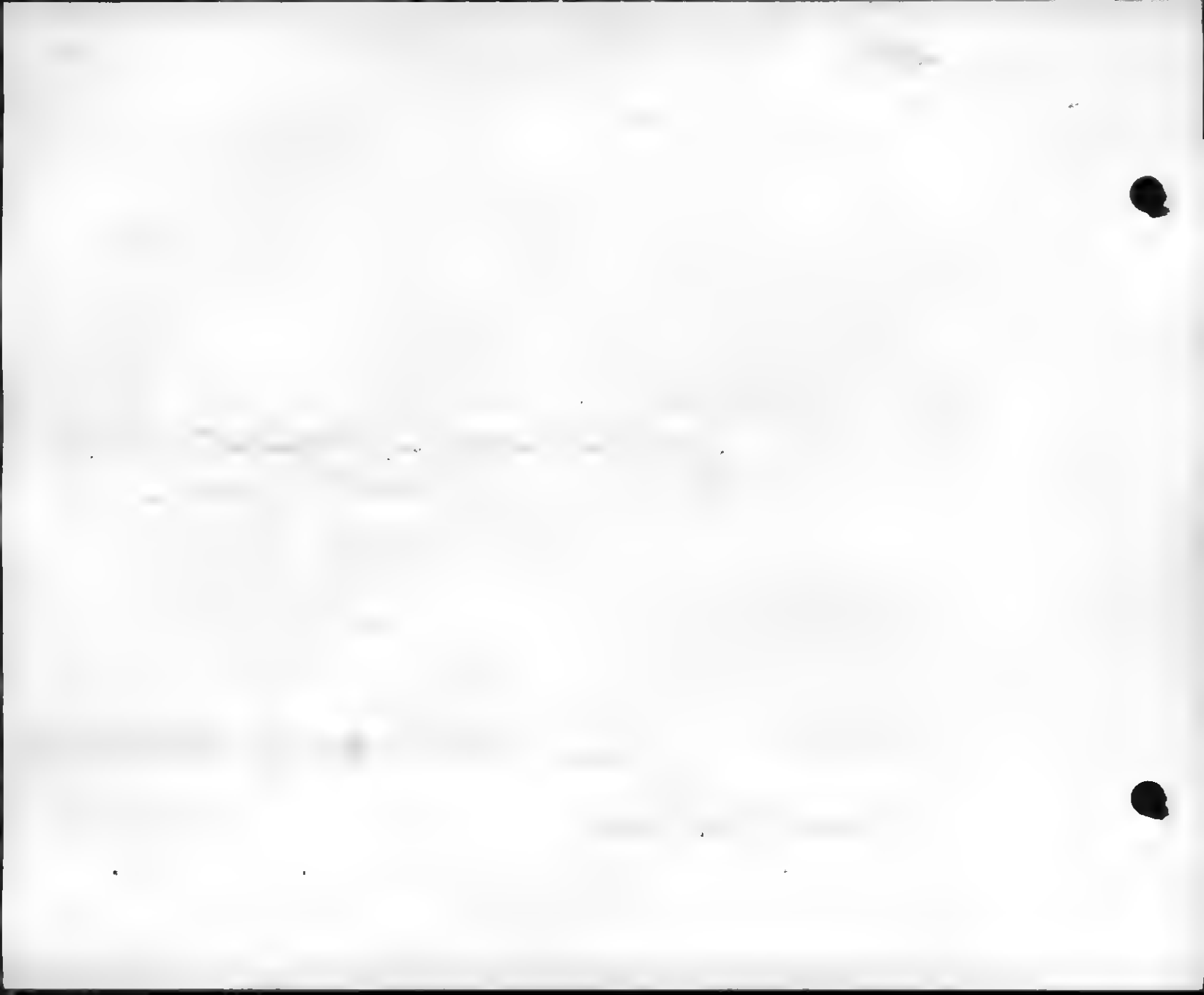
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-5 (4)
30M REV 1/68

MD 05197

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) William Henry KIMBALL			2a. DATE OF DEATH Month 4 Day 28 Year 68		2b. HOUR 7:30 PM
3. SEX M	4 RACE W	5 DATE OF BIRTH 1-31-1908		6. AGE (In years last birthday) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel Md		
10. CITY OR TOWN OF DEATH Annapolis	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7 KOMAR DR.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CIVIL SERVICE	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.	13b. COUNTY A.H.	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 7 KOMAR DR.	
14. FATHER'S NAME First Middle Last JOHN S. KIMBALL		15. MOTHER'S MAIDEN NAME First Middle Last MARY E. LAMB			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WW II		16b SOCIAL SECURITY NO 213-14-5621		17 INFORMANT KEVIN M. KIMBALL Address # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4/29 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Do.t. 5 yr.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from 8.8. 1968 to 4-28-68 , that (I) (we) last saw the deceased alive on 4-24-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE Frank M. Shipley		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-29-68	
22d. PHYSICIAN'S NAME (Type) Frank M. Shipley, M.D.		22e. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-30-68		23c. NAME OF CEMETERY OR CREMATORY ST MARY'S	
23d. LOCATION (City or Town) (County) (State) Annapolis A.H. MD.					
24. FUNERAL DIRECTOR John M. Taylor & Sons (Annapolis, Md)		25a. REC'D BY REGISTRAR DATE APR 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

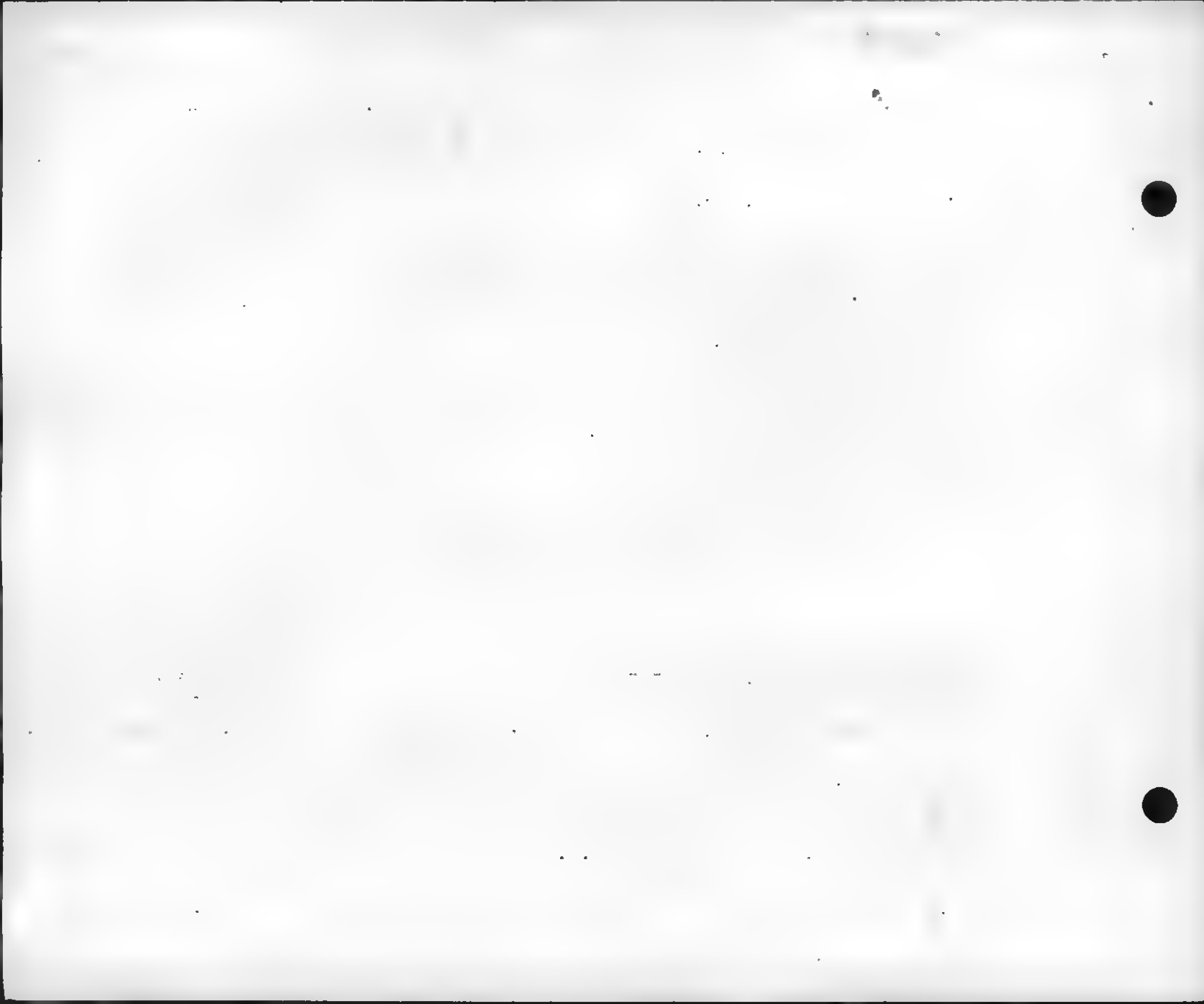
05593

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First ELMER	Middle GLENN	Last KINCER, JR.	2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 4-3-68	2b HOUR M
3 SEX Male	4 RACE White	5 DATE OF BIRTH 9-15-40	6 AGE (in years last birthday) 27 YRS	7 UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month April Day 3 Year 1968	2d HOUR 9:15 PM
7a BIRTHPLACE (State or foreign country) VIRGINIA	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Anne Arundel Md.			
10 CITY OR TOWN OF DEATH Annapolis	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital (DOA)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALESMAN	12b KIND OF BUSINESS OR INDUSTRY REAL ESTATE			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b COUNTY Charles	13c CITY OR TOWN Waldorf	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 803 Kenyon Avenue		
14. FATHER'S NAME First ELMER Middle GLENN Last KINCER JR.			15. MOTHER'S MAIDEN NAME First BESSIE Middle HAWKINS Last HAWKINS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO 224-52-9664		17. INFORMANT CATHERINE P. KINCER WALDORF, MD.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries 816.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 240.4						
19a. DATE OF OPERATION 4-7-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? HOPEX			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year 9:05 P.M. 4-3-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver of car which went through construction barrier and over bank		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f. LOCATION Street or R.F.D. No Rt. #2-Baltimore Beltway City or Town Anne Arundel State Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.			22b. DATE SIGNED April 4, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-7-68		23c. NAME OF CEMETERY OR CREMATORY KIMBERLIN CEMETERY		23d. LOCATION (City or Town) (County) (State) RURAL RETREAT, VA.
24. FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD.				25a. REC'D BY REGISTRAR APR 8 - 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "PMS". Page 5 may be retained for your files.

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35099

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR		
JOHN		K.		KISINER				APRIL 3 1968		3	PM				
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month	Day	Year	2d HOUR
MALE	WHITE	9-15-08		59 YRS		MONTHS DAYS		HOURS MIN		APRIL 3rd		19	68	3	PM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH									
Pennsylvania		U. S.				ANNE ARUNDEL COUNTY								Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY									
GLEN BURNIE		North Arundel Hospital		R C A Dealer		Radio & T.V.									
13a USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER							
MD.		A.A.		RIVIERA BEACHES		NO <input checked="" type="checkbox"/>		140 MEADOW ROAD							
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last	
John Henry Kisiner								Mamie Warner							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS									
No		162-05-7638		Mrs. Hattie Kisiner- same											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												Instant			
DUE TO, OR AS A CONSEQUENCE OF															
(b) Coronary Arteriosclerosis												Years			
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
NONE															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
		19													
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		Charles H. Wirth, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		22b DATE SIGNED		4/13/68	
EXAMINER'S NAME (Type)		Charles H. Wirth, M.D.													
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)					
Burial		4-6-1968		Beth. Lutheran Church Cem.		York County, Pennsylvania									
24 FUNERAL DIRECTOR		George J. Gonce-4001 Ritchie Hgwy., Baltimore, Md.		25a READ BY REGISTRAR		25b REQUIRED SIGNATURE									
				APR 8 - 1968		John J. Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1
30M REV 1968

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR					
3 SEX			4 RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>dissecting aneurysm of aorta</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 day</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <u>April 10, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Ray M. Smith</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>April 10, 1968</u>					
22d. PHYSICIAN'S NAME (Type) <u>Dr. M. Smith</u>						22e. ADDRESS <u>1414 N. ...</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						DATE <u>APR 16 1968</u>		<u>Charles Judge</u>			



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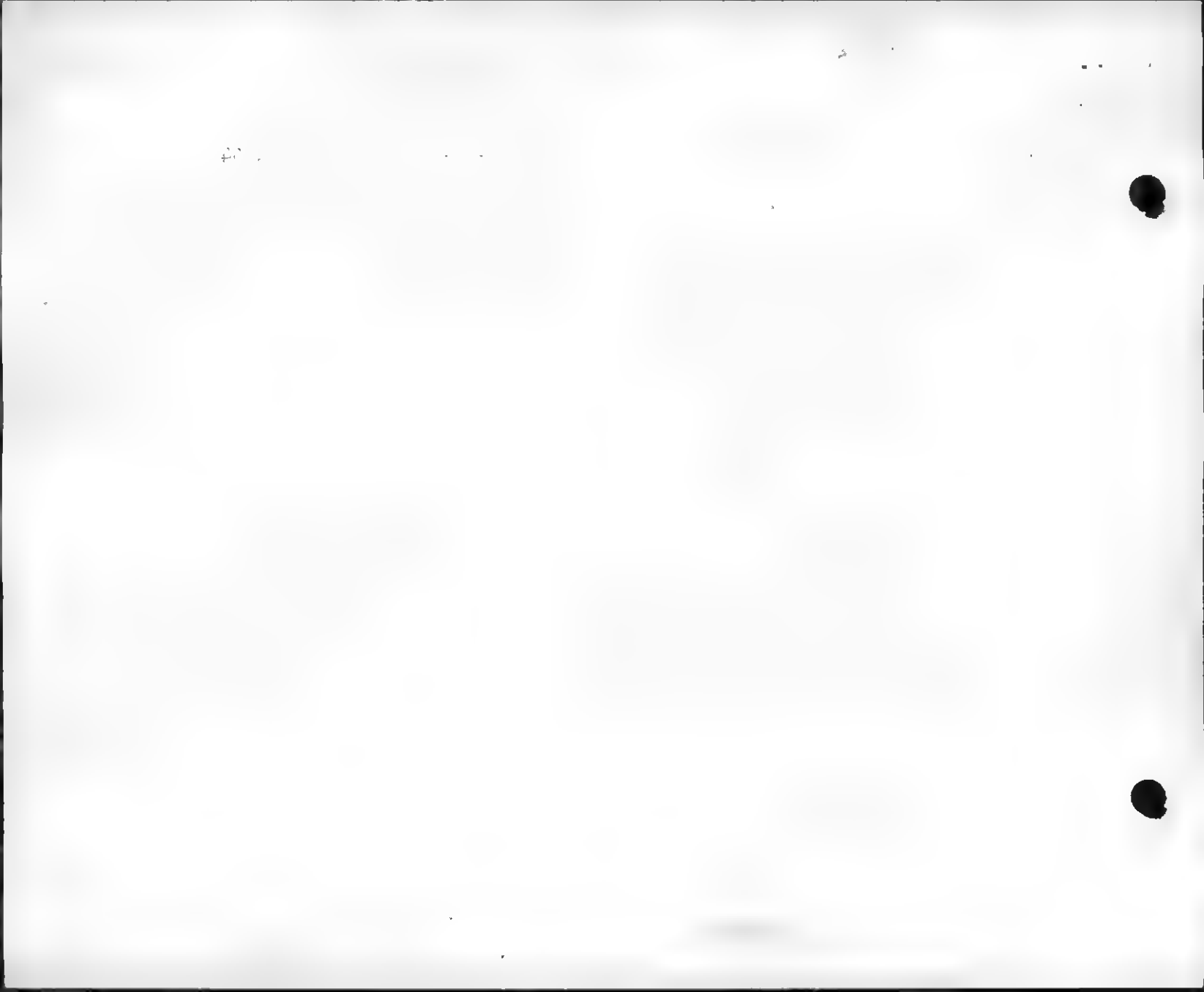
VR A15 (4)
30M REV. 1-68

05101

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Esther			First Middle Last			2a. DATE OF DEATH Month 4 Day 2 Year 1968			2b. HOUR P 3:05 M		
3 SEX Female			4 RACE White			5. DATE OF BIRTH 9-10-93			6. AGE (In years last birthday) 74 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md		
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Lwn Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Odenton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER Box 300 Jackson Grove Rd.			14. FATHER'S NAME First Arthur Middle Phelps Last Phelps			15. MOTHER'S MAIDEN NAME First Maggie Middle Hood Last Hood					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 214-54-9382			17. INFORMANT Patient's chart			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Chronic Coronary Heart Disease 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic Mellitus									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Uremia, Bowel Obstruction											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4/1/1968 to 4/2/1968 , that (I) (we) last saw the deceased alive on 4/2/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE O. Dorkan			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 4/2/1968		
22d. PHYSICIAN'S NAME (Type) O. DORKAN			22e. ADDRESS 325 Hospital drive #104, G. Blumberg								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/5/68			23c. NAME OF CEMETERY OR CREMATORY Nichols Bethel CH. Cemetery			23d. LOCATION (City or Town) (County) (State) Odenton, Maryland		
24. FUNERAL DIRECTOR Robert P. Moore			ADDRESS Singleton Funeral Home/Glen Burnie, Md.			25a. REC'D BY REGISTRAR DATE APR 4 - 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

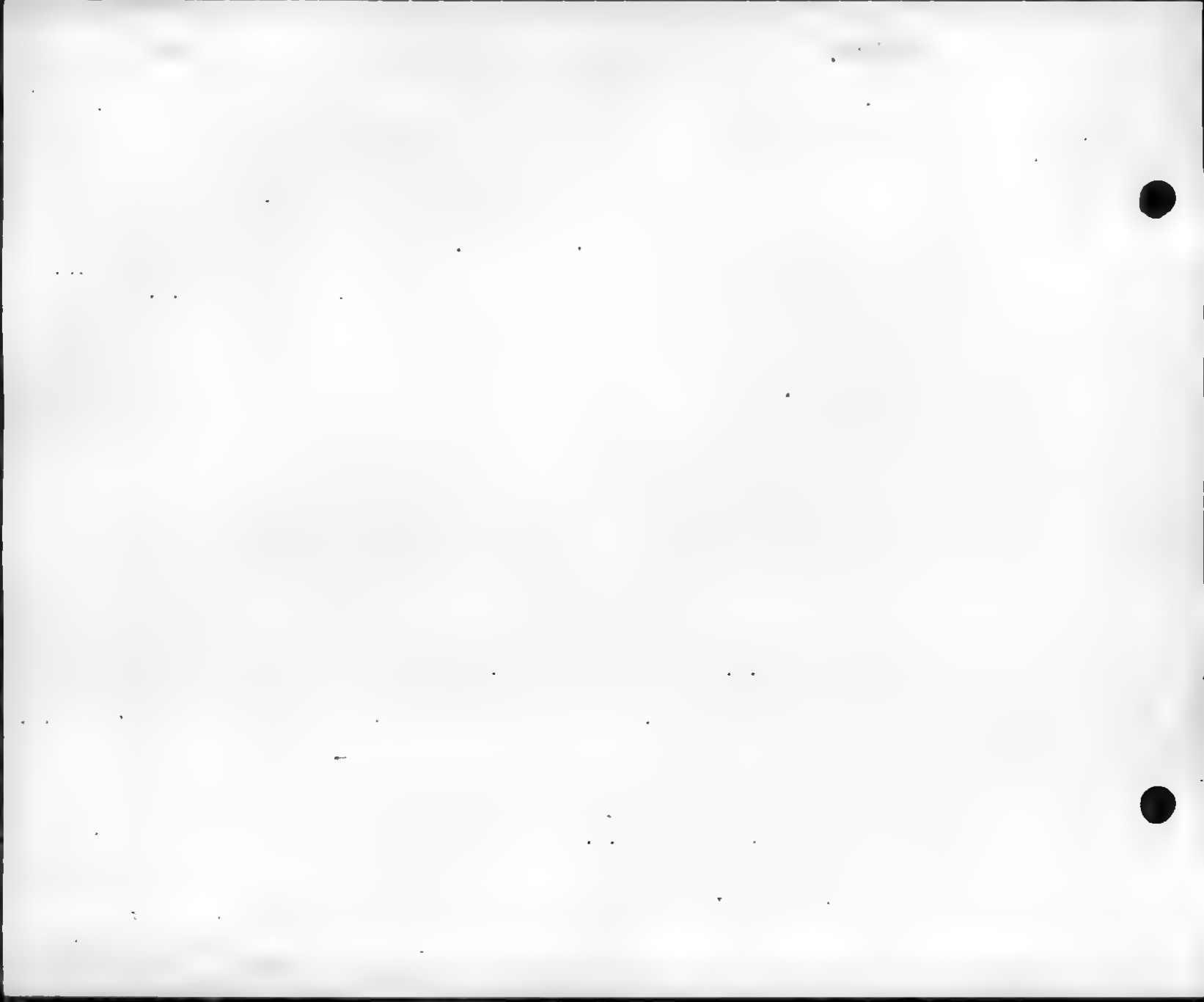
VR A15M 19
10M REV 68

05102

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5106 112

1. DECEASED NAME (Type or Print) CHISHALM		First Middle Last LEWIS		2a. DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> April 11, 1968		2b. HOUR OF DEATH 7:30 AM	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH	6. AGE (In years last birthday) 32 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month April Day 11 , Year 1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Linthicum Hgts.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER D.C. 111-4th St. S.E. Washington		14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hanging 753X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year A.M. 4-11-1968 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) UNK.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Linthicum Hgts.		21f. LOCATION Street or R.F.D. No. Linthicum Hgts.		City or Town County State Anne Arundel M.D.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 4-12-68	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-29-68		23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR DATE MAY 2 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR M	
CLIFTON JOSEPH LEWIS							April 17 1968		M
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 IF UNDER YEAR MONTHS DAYS	
male		cauc.		Nov. 25, 1903		64 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		USA				Anne Arundel		Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		1411 Poplar St. Annapolis		retired painter		US Gov't			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Annapolis				1411 Poplar St.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Joseph Lewis			Minnie Tanner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
yes		213-30-0694		Clifton K. Lewis - 1411 Poplar St., Annapolis		Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Ac. Pulmonary Edema</u> <u>442x</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ac. & Chs. Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>yes</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased, from <u>Jan 1952</u> to <u>4/17/1968</u> , that (I) (we) last saw the deceased alive on <u>4/16/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Minnie Klawans</u>						22c. DATE SIGNED <u>4/18/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>M.F. KLAUANS, M.D.</u>						22e. ADDRESS <u>31 SOUTHGATE AVE</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/20/68		Cedar Bluff		Annapolis A.A. Md.			
24. FUNERAL DIRECTOR <u>Beverley E. Hopping</u> <u>Hopping Funeral Home - Annapolis, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>APR 22 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Francis Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATE

1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH			2b. HOUR	
WILLIAM		D.		LEWIS		MXX Month 4 Day 2 Year 68					M	
3 SEX		Male		4. RACE		White		5 DATE OF BIRTH			6 AGE (In years last birthday)	
						4/21/08		59 YRS			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Maryland						A.A. County Md						
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY						
Pasadena		North Arundel										
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER				
Maryland		A.A.		Pasadena				Box 156. Pasadena				
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME				
David		Lewis		Unk								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address						
Yes, no, or unknown) yes				Family		Same						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u> <u>16d1</u>											1 year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
16-2												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>3-29</u> , 19 <u>68</u> , to <u>3-30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3-30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE		22c DATE SIGNED										
<u>Charles R. MacDonald</u>		<u>4-2-68</u>										
22a PHYSICIAN'S NAME (Type)		22e ADDRESS		22c DATE SIGNED								
Charles R. MacDonald		325 Hospital Drive, Glen Burnie, Md.										
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)						
Burial		4/5/68		Glen Haven Mem Park		Glen Burnie AA Co Md						
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE						
<u>Mc Cully F.H.</u>		<u>737 Patuxent Ave</u>		<u>APR 3 - 1968</u>		<u>Charles Judge</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
ALEXANDER		-		LINTZ SR.	4 Month 22 Day 1968		10 45P	
3. SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male	White		July 7, 1894		73 YRS			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Estonia	U. S. A.				Anne Arundel			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie	Box 87 Shoreland Dr.		Ret. Carcenter					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.	A. A.		Glen Burnie				Box 87 Shoreland Dr.	
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
Matthew	-		Lintz	Anna		-		Lenna
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No			180-14-0968		Hilda Lintz (Wife)		As above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 456.7 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10/4/1963, to 4/22/1968, that (I) (we) last saw the deceased alive on 4/20/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Edmond I. Moushabeck</u> M.D.					22c. DATE SIGNED 4/23/68		22d. PHYSICIAN'S NAME (Type) EDMOND I. MOUSHABEK	
22e. ADDRESS 510 MARLEY STATION ROAD GLEN BURNIE, Md. 21061								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		4/23/68		Glen Haven Cemetery		Glen Burnie, A. A. Md.		
24. FUNERAL DIRECTOR Raymond C. Fink Glen Burnie, Md.					25a. REC'D BY REGISTRAR DATE APR 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

<div style="text-align: center;"> <p>05106</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>Item 7a Film 0406</p> <p>CERTIFICATE OF DEATH</p> </div>											
1. DECEASED-NAME (Type or print) EDWIN MAURICE LIPSCOMB						2a. DATE OF DEATH Month 4 Day 27 Year 68			2b. HOUR 8:15 AM		
3. SEX MALE		4. RACE white		5. DATE OF BIRTH 8-7-94			6. AGE (In years last birthday) 73 YRS		IF UNDER 1 YEAR MONTHS 7 DAYS 15		IF UNDER 24 HRS HOURS 15 MIN.
7a. BIRTHPLACE (State or foreign country) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WISSEX Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Glen Burnie Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) N.A.C.C.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Railroad Engineer			12b. KIND OF BUSINESS OR INDUSTRY (R.R.)		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY BALT.		13c. CITY OR TOWN BALT.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2510 ARBUTHNOT AVE.		
14. FATHER'S NAME First Phillip Middle Daniel Last Lipscomb						15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO				16b. SOCIAL SECURITY NO -		17. INFORMANT His family and records Address -					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastatic disease 1922 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) spinal cancer DUE TO, OR AS A CONSEQUENCE OF (c) -										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1968											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. 19 Month 4 Day 30 Year 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No 1500 City or Town Baltimore County Baltimore State Md.					
22a. I certify that (I) (this hospital) attended the deceased from 4/30/68 , 19 68 , to 4/30/68 , 19 68 , that (I) (we) last saw the deceased alive on 4/30/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE Orlando C. Ramos MD DEGREE MD						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4-27-68		
22d. PHYSICIAN'S NAME (Type) ORLANDO C. RAMOS MD						22e. ADDRESS 1500 Calverton Rd. Balt 21218 Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/30/68			23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park			23d. LOCATION (City or Town) Dorsey (County) Howard Co. (State) Md.		
24. FUNERAL DIRECTOR McCall Funeral Home ADDRESS 237 Patapsco Ave. 21225						25a. REC'D BY REGISTRAR APR 29 1968 DATE			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-68
304 REV 2-68

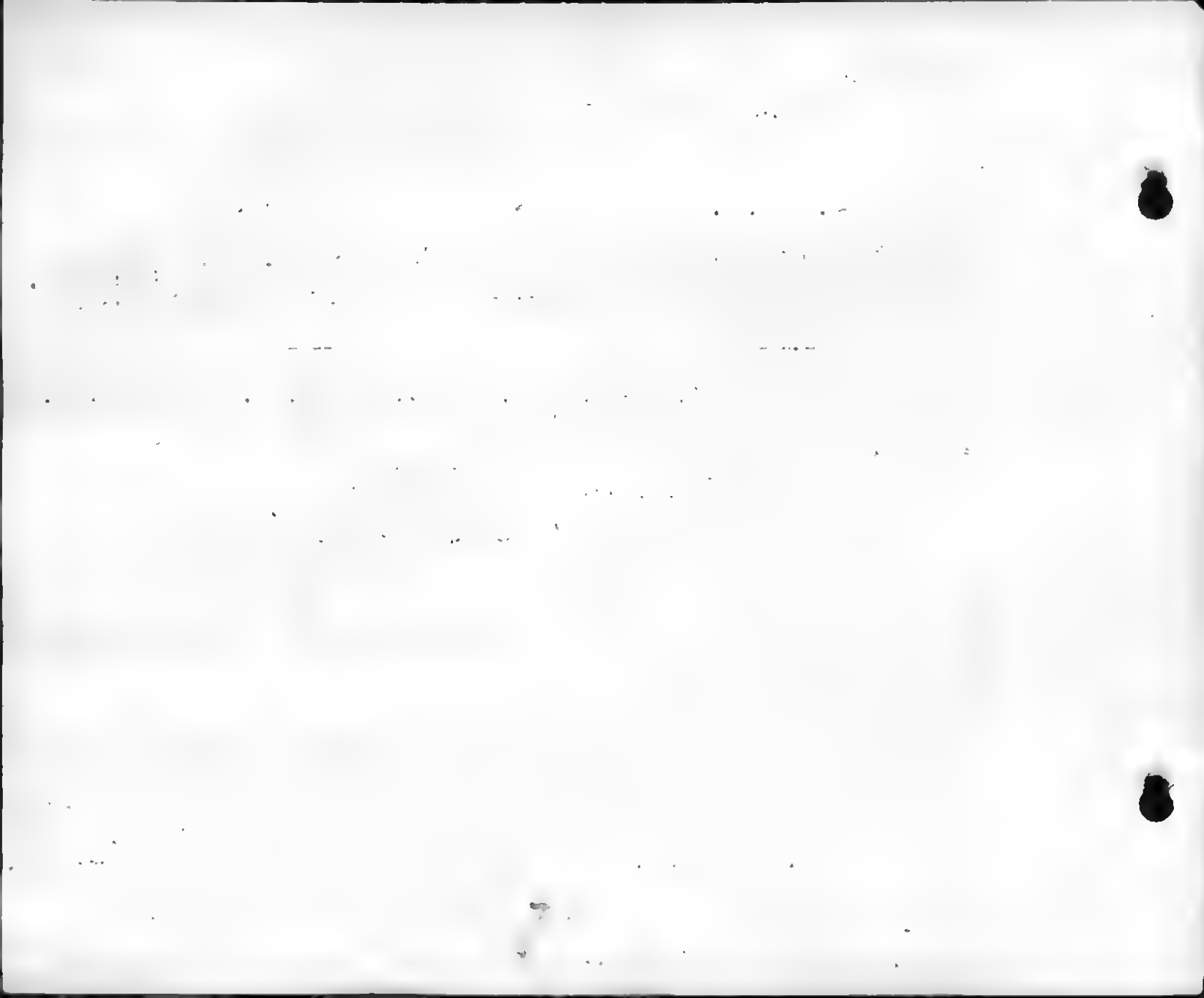
MD 05107

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MD 05107

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Katherine Theresa Lotz			2a. DATE OF DEATH Month 4 Day 8 Year 1968			2b. HOUR M			
3 SEX Female		4. RACE White		5. DATE OF BIRTH 5/4/1876		6 AGE (in years last birthday) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md			
10. CITY OR TOWN OF DEATH Millersville, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Knollwood Manor Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mattress maker		12b. KIND OF BUSINESS OR INDUSTRY Mattress			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b. COUNTY AA.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 207th & Outing Ave.,	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 216-05-7482		17. INFORMANT Address Mr. Tribull, Box 494, Rt. S. Pasadena, Md.					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ray M. Smith		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED April 8, 1968			
22d. PHYSICIAN'S NAME (Type) Ray M. Smith, M. D.		22e. ADDRESS Mahon professional Bldg. Severna Park, M.d.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-10-1968		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hgwy., Baltimore		ADDRESS		25a. REC'D BY REGISTRAR APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

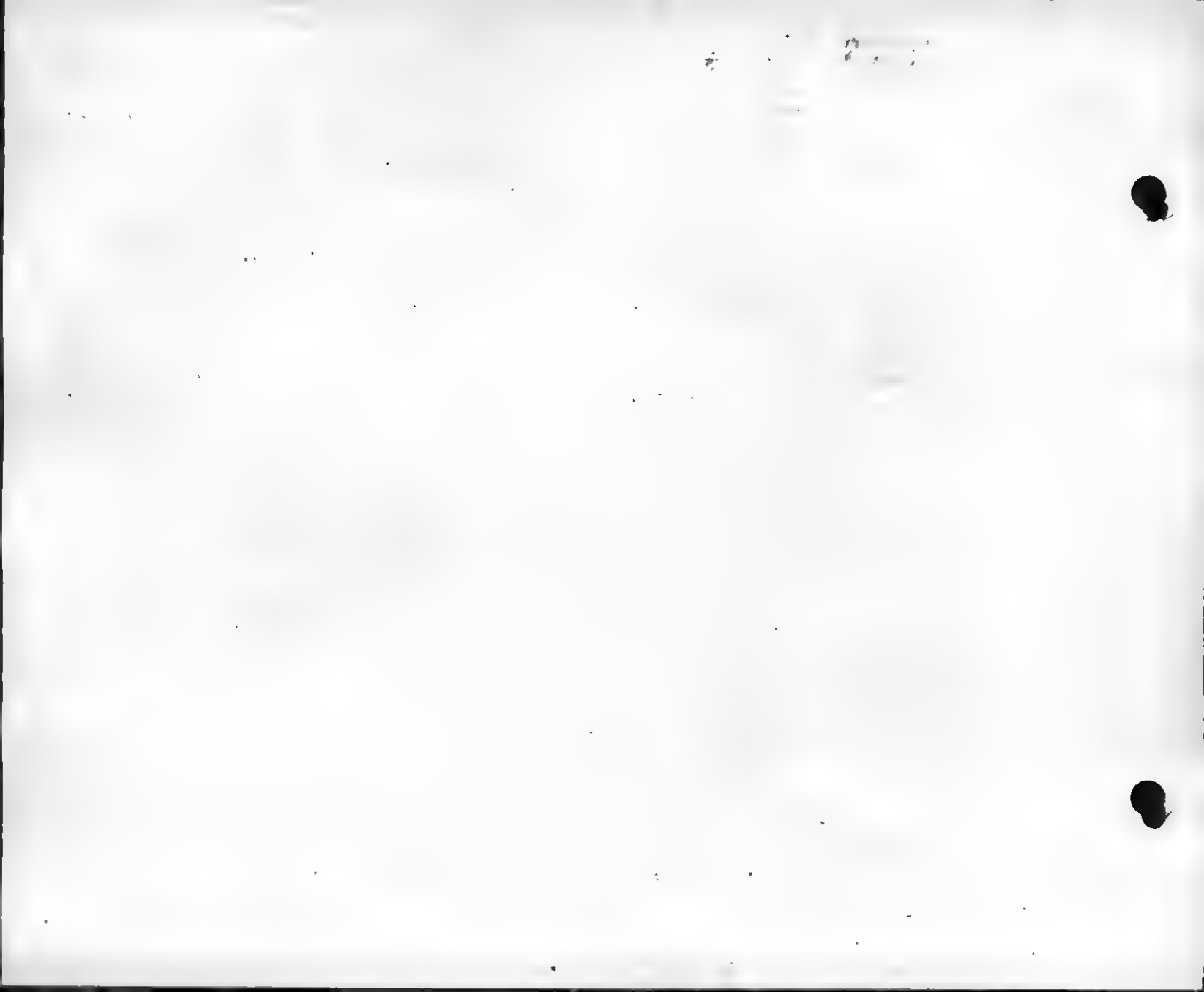
VR A15 (4)
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05108

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Elizabeth				LOVERING	April 9 1968		5:10A M	
3 SEX	4 RACE	5. DATE OF BIRTH			6 AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Female	Caucasian	August 3 1881			86			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
PA.	USA			Anne Arundel Md.				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Millersville		Knollwood Manor Nursing			Milliner (ret.)		retail sales	
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before adm ssion) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
Maryland		Anne Arundel	Odenton		1207 Winer Rd			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
Henry			Rush		Euth			White
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address		
No		180-07-3371		Thomas Lovering (husband)		1207 Winer Rd Odenton, Md.		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gram-negative septicemia								5 days
4339 DUE TO, OR AS A CONSEQUENCE OF (b) Urinary tract infection								3 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Left hemiparesis from cerebral thrombosis								more than one year
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
Arteriosclerosis, general and cerebral-								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
None					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (the hospital) attended the deceased from January 4, 1968, to April 9, 1968, that (I) (we) last saw the deceased alive on April 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
Charles W. Kinzer								April 9, 1968
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
Charles W. Kinzer, M. D.				16 Murray Ave., Annapolis, Maryland				
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Re Burial		4/11/68		Dunmoore Cemetery		Dunmoore		Dackawana Pa.
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REG STRAR		25b. REGISTRAR'S SIGNATURE
Hopping Funeral Home - Annapolis, Md.				Charles E. Hopping		APR 11 1968		Charles Judge



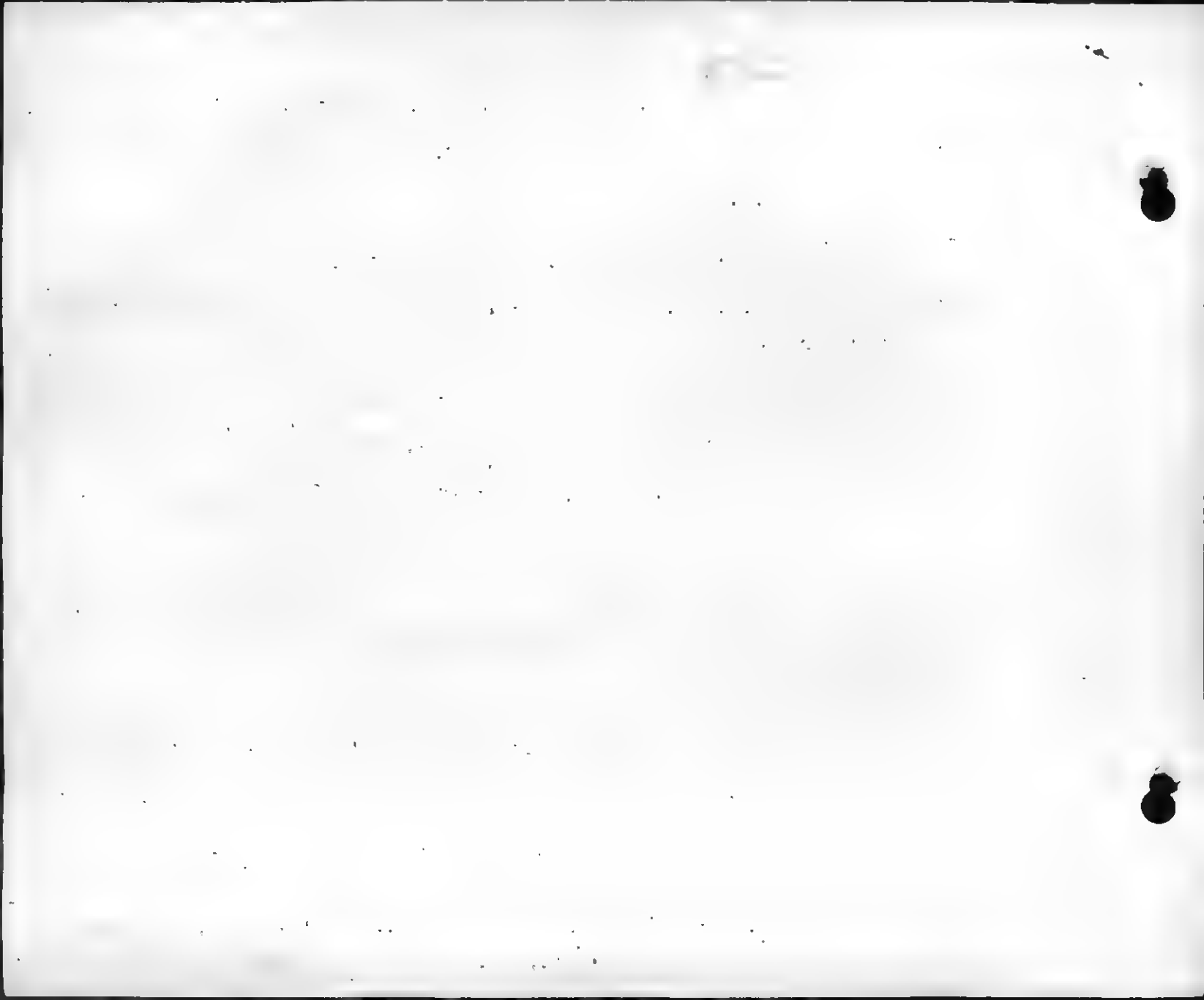
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 6 Film G398
4/15/68 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First <u>MUEL</u> Middle <u>J.</u> Last <u>LUI CONO * SR.</u>		2a DATE OF DEATH <u>April</u> Month <u>10</u> Day <u>1968</u> Year		2b HOUR <u>1</u> P.M.	
3 SEX <u>Male</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>26 Oct. 1915</u>	
6 AGE (In years and birthday) <u>52</u> YRS		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN <u></u>	
7a BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <u>Anne Arundel</u> Md					
10 CITY OR TOWN OF DEATH <u>Glen Burnie</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>101 Marley Neck Road</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Bocher</u>	
12b KIND OF BUSINESS OR INDUSTRY <u>Eddies Sup M</u>		13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>A.A. CO.</u>	
13c CITY OR TOWN <u>Glen Burnie</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>101 Marley Neck Road</u>	
14 FATHER'S NAME First <u>Joseph</u> Middle <u>Lui</u> Last <u>Luiacono</u>		15 MOTHER'S MAIDEN NAME First <u>Rose</u> Middle <u>Marino</u> Last <u></u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>11</u>		16b SOCIAL SECURITY NO <u>217 05 6933</u>		17 INFORMANT <u>Verda E. Luiacono - Same as 13</u> Address <u></u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma entire anterior & lateral neck.</u> <u>414</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Squamous cell Carcinoma tongue</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 weeks</u> <u>35 Months</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>14</u>					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21f LOCATION Street or R.F.D. No City or Town County State	
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>24 April, 1965</u> to <u>10 April, 1968</u> , that (I) (we) last saw the deceased alive on <u>6 March, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Arthur G. Siwinski</u> MD				22c DATE SIGNED <u>10 April 68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Arthur G. Siwinski</u>				22e ADDRESS <u>836 Park Ave</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE <u>13 Apr. 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>	
23d LOCATION (City or Town) <u>Glen Burnie, Maryland</u>		23e. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			
24 FUNERAL DIRECTOR <u>Robert P. J...</u>		ADDRESS <u>Singleton Funeral Home/Glen Burnie, Md.</u>		25a REC'D BY REGISTRAR DATE <u>APR 11 1968</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05170

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <i>Paul</i>		Middle		Last		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <i>4 7 68</i>				2b HOUR <i>4</i> M	
3 SEX <i>M</i>	4 RACE <i>W</i>	5. DATE OF BIRTH <i>JULY 20 1948</i>	6 AGE (in years lost birthday) <i>19</i> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS Min		IF UNDER 24 HRS HOURS Min		2c DATE PRONOUNCED DEAD Month <i>4</i> Day <i>7</i> Year <i>68</i>		2d HOUR <i>4</i> M	
7a BIRTHPLACE (State or foreign country) <i>Pa</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>AA. CO.</i>					
10 CITY OR TOWN OF DEATH <i>Port-Meade</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>S.O.A. Barabrough</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>clerk</i>		12b KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt</i>					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b COUNTY <i>HOWARD</i>		13c CITY OR TOWN <i>N. LAUREL</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Frank Rd</i>			
14 FATHER'S NAME First <i>RUDOLPH</i> Middle <i>MACEY</i> Last		15 MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Runge</i> Last		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <i>no</i>		16b. SOCIAL SECURITY NO		17. INFORMANT <i>Rudolph Macey</i> ADDRESS <i>Laurel Md.</i>			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>multiple injuries</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>10-7</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10-7</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1224</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. ADJUSTMENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year <i>4-7 1968</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Auto accident - the funeral over</i>							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>		21f LOCATION Street or R.F.D. No <i>Ch. 198 & South Spring Road</i> City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>E. Linhart</i>		EXAMINER'S NAME (Type) <i>E. LINHART</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>4-7-68</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-10-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Marble Hill</i>		23d LOCATION (City or Town) <i>Pa</i> (County) <i>Pa</i> (State) <i>Pa</i>		24 FUNERAL DIRECTOR <i>Walter Samelson</i> ADDRESS <i>Laurel Md</i>			
25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>APR 15 1968</i>							

Richard M. Carey
Lambert, Mo.

on

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 141 (1)
304 REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05111

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) CRISTOBAL (NMN) MATIZ			2a DATE OF DEATH Month APRIL Day 6 Year 1968		2b HOUR 8:45P
3. SEX M	4 RACE W	5 DATE OF BIRTH 8-20-1891		6 AGE (n years last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a BIRTHPLACE (State or foreign country) PHILIPPINES		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH ANNAPOLIS		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL, ANNA., MD.		9. COUNTY OF DEATH ANNE ARUNDEL Md	
13a USUAL RESIDENCE (Where deceased lived, if inst. tuton: Residence before admission) STATE MD.		13b COUNTY A.A.Co.		13c CITY OR TOWN ANNAPOIS	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 75 SILOPANNA RD.		12b KIND OF BUSINESS OR INDUSTRY Ret.	
14. FATHER'S NAME First Apolonio Middle Matiz Last Matiz		15 MOTHER'S MAIDEN NAME First Matotino Middle Somike Last Somike		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give year and conditions of service) WW I+II	
16b SOCIAL SECURITY NO.		17 INFORMANT Polita V. Matiz #13		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 42 (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Complicated arteriosclerosis					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) THORACIC AORTIC ANEURYSM - Atherosclerosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21f. LOCATION Street or R.F.D. No. City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on APRIL 6 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael F. Fornes				22c. DATE SIGNED APRIL 7, 1968	
22d. PHYSICIAN'S NAME (Type) M. F. FORNES, LCDR MC USN				22e. ADDRESS NH, ANNAPOLIS, MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-10-68		23c. NAME OF CEMETERY OR CREMATORY ST. MARYS	
23d. FUNERAL DIRECTOR John M. Lyons Sons		23e. ADDRESS Annapolis, Md.		23f. LOCATION (City or Town) (County) (State) ANNAPOLIS A.A. MD.	
24. REC'D BY REGISTRAR DATE APR 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

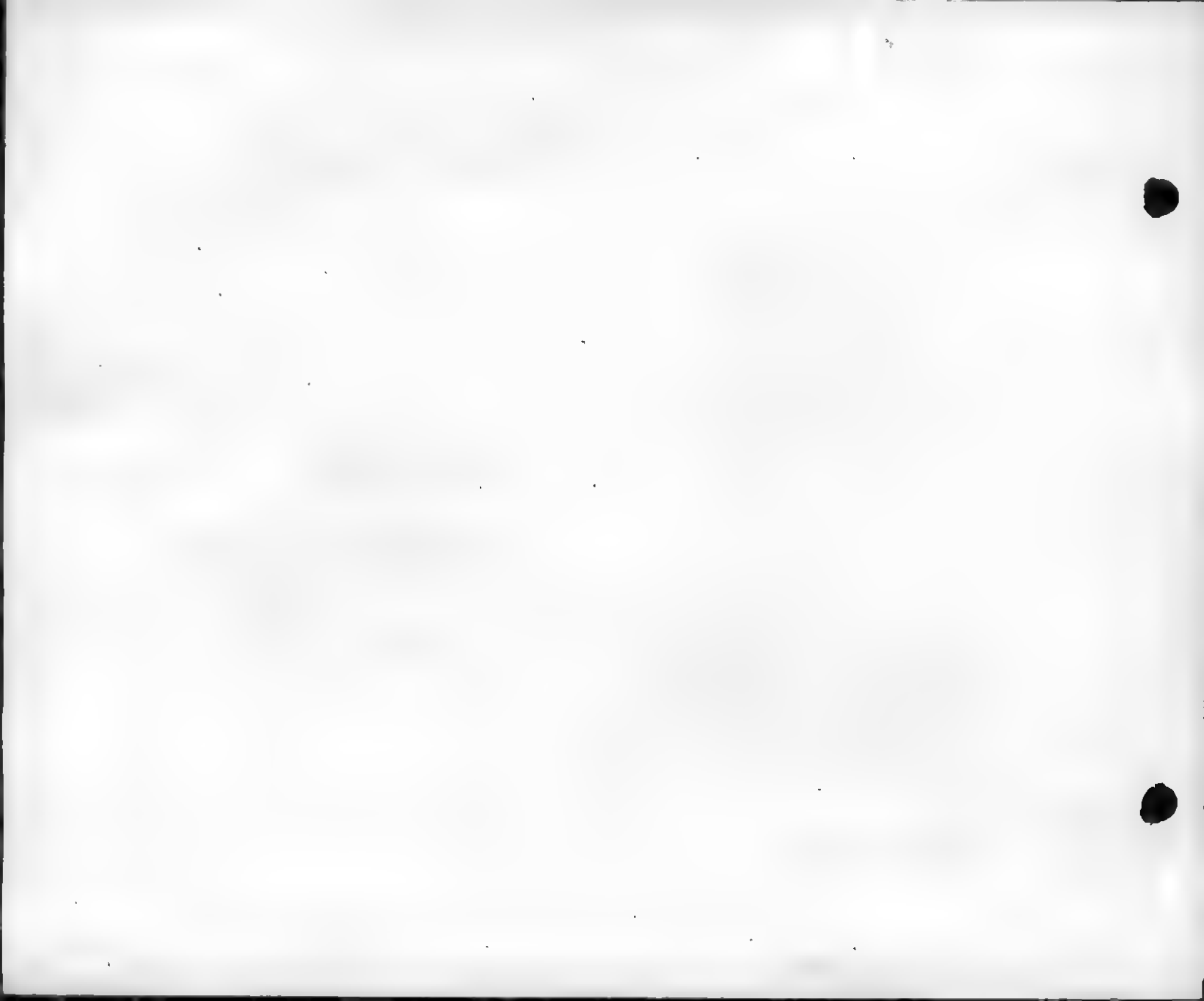


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or Print) <i>Charles NMN Matthews</i>						2a DATE KNOWN OF DEATH Month <i>4</i> Day <i>7</i> Year <i>68</i>		2b HOUR <i>P</i>					
3 SEX <i>M</i>		4 RACE <i>C</i>		5 DATE OF BIRTH <i>12-23-1932</i>		6 AGE <i>35</i> YRS		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____			
7a BIRTHPLACE (State or foreign country) <i>Anne Arundel</i>				7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>A. A. Co. Md.</i>					
10 CITY OR TOWN OF DEATH <i>Annapolis</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>D.O.B. - Anne Arundel Gen</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Laborer - Cleaner</i>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if not tuition. Residence before admission) STATE <i>MD</i>				13b COUNTY <i>AA CO</i>		13c CITY OR TOWN <i>Annapolis</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>59 Clay St</i>			
14 FATHER'S NAME <i>George NMN. Matthews Sr</i>						15 MOTHER'S MAIDEN NAME <i>Elsie NMN Brooks</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16b SOCIAL SECURITY NO. <i>Unknown</i>		17 INFORMANT <i>George Matthews Sr.</i>				ADDRESS <i>ANNAPOLIS - MD</i> <i>59 Wash. St</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Rheumatic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>416</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No _____		City or Town _____		County _____		State _____			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>E. Linhart</i>				EXAMINER'S NAME (Type) <i>E. Linhart</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
								ADDRESS (Street, city, town, or county) <i>A.A. Co.</i>		22b. DATE SIGNED <i>4-7-68</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>Apr. 11-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Pine Lawn</i>		23d. LOCATION (City or Town) <i>Annapolis - Md.</i>		(County) _____		(State) _____	
24. FUNERAL DIRECTOR <i>Charles E. Hicks</i>						ADDRESS <i>Annapolis Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>Apr 15 1968</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

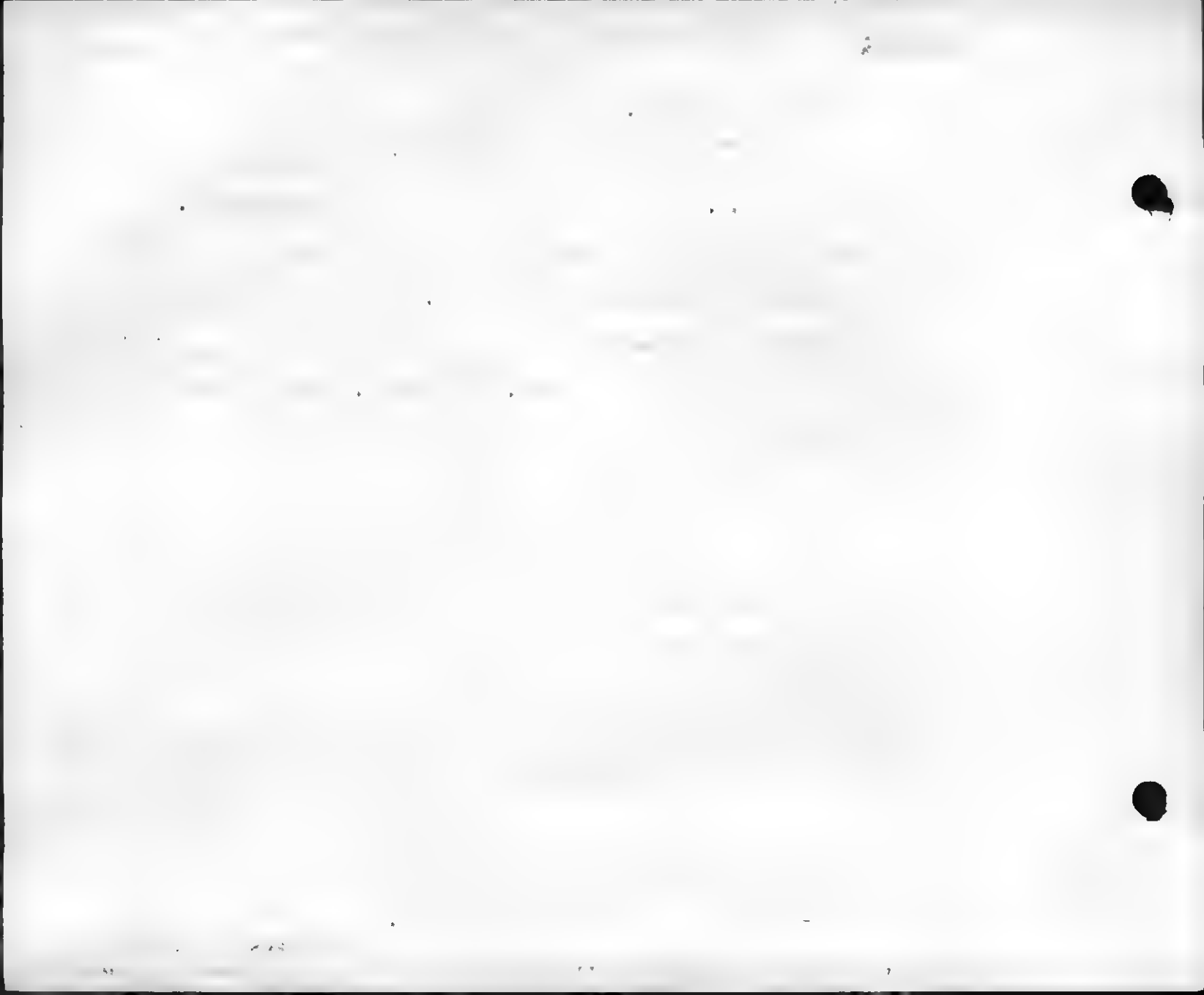
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05113		1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>68</u>		2b. HOUR <u>10 P.</u>		
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 13, 1895			6. AGE (In years lost birthday) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Co.					
10. CITY OR TOWN OF DEATH Riviera Beach		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 237 Kenwood Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Riviera Beach		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 237 Kenwood Road			
14. FATHER'S NAME First Middle Last Charles Heiderman		15. MOTHER'S MAIDEN NAME First Middle Last Margaret O'Neill									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO (If yes give year or dates of service)		17. INFORMANT Mrs. Catherine T. Czako - same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>essential hypertension</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>9 years</u> <u>9 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>none</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> , 19 <u>58</u> , to <u>4/11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R.M. McLaughlin, M.D.</u> DEGREE		22c. DATE SIGNED <u>4/11/68</u>		22d. PHYSICIAN'S NAME (Type) <u>R.M. McLAUGHLIN</u>		22e. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-15-1968		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore		25a. REC'D BY REGISTRAR DATE APR 16 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

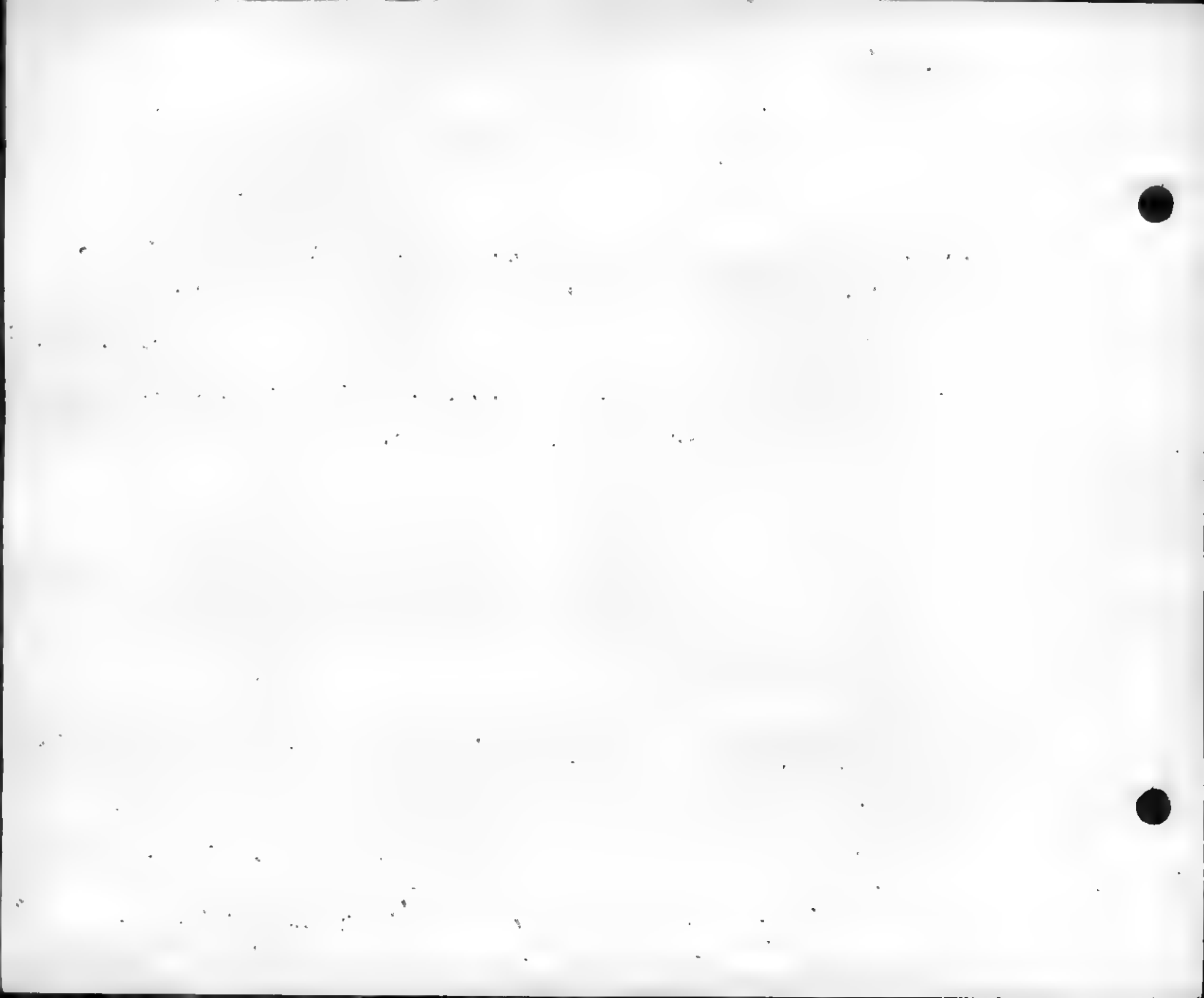
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05114

Item 6 Film 64001111

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Frances Cambas				McNulty	14 Month 14 Day 68 Year		1:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		Cau.		2 August 1911		27 58 YRS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. M.D.
Ohio		U.S.A.				Ann Arundel		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Ft. Geo. G. Meade		Kimbrough Army Hosp.		Secretary		Civil Service		
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER		
Md.		Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		176 Lauren Dr.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address
George		Cambas		Anaatacia		Vilanstaupauls		
16a. YES, NO, OR UNKNOWN		16b. SOCIAL SECURITY NO.		17. INFORMANT		17a. ADDRESS		
NO		107-07-8178		Mr. Robert McNulty same as 13e and 13c				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Breast Carcinoma</u> <u>174 X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <u>Joel Curtis</u> attended the deceased <u>Frances Cambas McNulty</u> and that in (my) <u>(we)</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED		
<u>Joel Curtis</u>		Joel Curtis CPT, MC		KIMBROUGH ARMY HOSP. FGGM Md. 20755		14 April 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
<u>CREMATION</u>		APRIL 1968		PINEVALE NATIONAL SEM		HARMONDALE ISLAND, N.Y.		
24. FUNERAL DIRECTOR		24a. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>Stallard</u>		550 W. BMD		DATE APR 25 1968		<u>Charles Judge</u>		



05115

MARYLAND STATE DEPARTMENT OF HEALTH

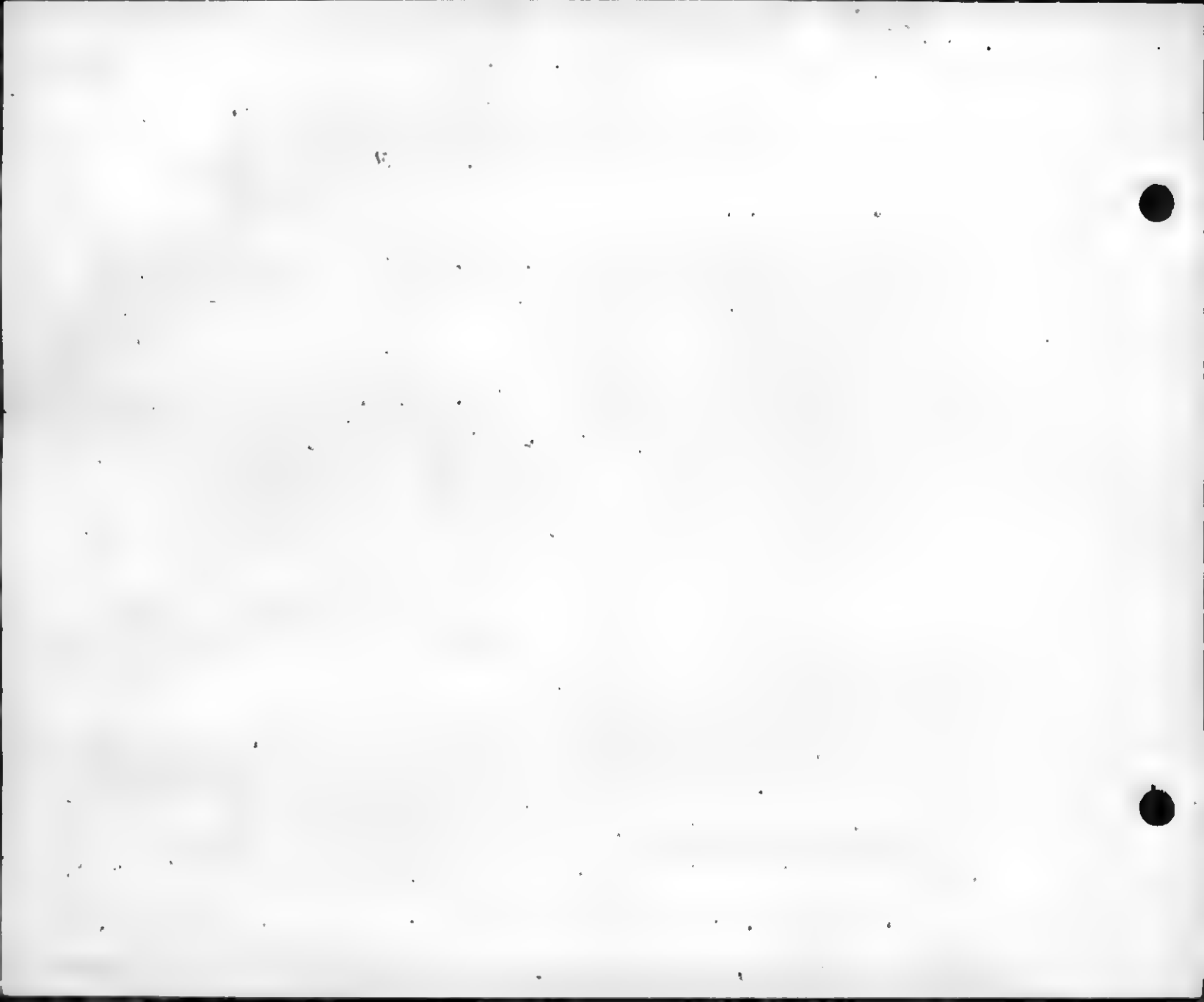
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 5 & 6 Film G399 4/18/68 **CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) Charles Lawrence METZ			2a DATE OF DEATH Month April Day 3 Year 1968		2b HOUR 5:40 P.
3 SEX Male	4 RACE White	5 DATE OF BIRTH Nov. 1, 1904/ 1903		6 AGE (In years last birthday) 63 64 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel		12b. KIND OF BUSINESS OR INDUSTRY Western Electric
10 CITY OR TOWN OF DEATH Annapolis		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Anne Arundel Gen. Hosp.		12a USAL OCCUPATION (Kind of work done during most of working life, even if retired) Tool Designer	
13a USAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b COUNTY Anne Arundel	13c CITY OR TOWN Arnold	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER Rt-1, Box-490	
14 FATHER'S NAME First Charles Middle Metz Last Metz		15. MOTHER'S MAIDEN NAME First Frieda Middle (unk) Last (unk)			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 216-03-7040	17 INFORMANT Mrs. Mary G. Metz, same as 13 Address (unk)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) acc v d DUE TO, OR AS A CONSEQUENCE OF (c) senect					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1960 , 19____, to 1968 , 19____, that (I) (we) last saw the deceased alive on 4-3-68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b SIGNATURE Robert R. Halperin MD DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c DATE SIGNED 4-4-68	
22d. PHYSICIAN'S NAME (Type) Robert R. Halperin				22e. ADDRESS P.O. Box 73 Severna Park	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 6 Apr. 68		23c NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	
24. FUNERAL DIRECTOR Markley Funeral Home, Glen Burnie, Md.		23d LOCATION (City or Town) (County) (State) Glen Burnie, MD, MD.		25a REC'D BY REGISTRAR Charles Judge	
25b REGISTRAR'S SIGNATURE Charles Judge		DATE APR 8 1968			

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CERTIFICATE OF DEATH

120

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P.	
George Herbert MEYERHOFF		George	Herbert	MEYERHOFF	April 9 1968		8:00 M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Y	W	Oct 15, 1908		39 YRS		MONTHS DAYS		HOURS MIN.
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md.		
N.J.	U.S.A			Anne Arundel				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis		H.A. General Hospt.		ENGINEER		CIVIL		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
MD.		A.A.	Severna Park	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		37 Whittier Parkway		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle Last
GEORGE		H. MEYERHOFF	ANNETTA	NEHLMAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address		
NO				CHRISTINE MEYERHOFF		#13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden regressive splenic</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Subphrenic abscess, post</u>								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>perforated duodenal ulcer</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
April 2, 1968								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or RFD No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>March 28, 1968</u> to <u>April 9, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Stephen B. Hiltabidle</u>				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>April 10, 1968</u>
22d. PHYSICIAN'S NAME (Type) Stephen B. Hiltabidle, M.D.				22e. ADDRESS 121 Cathedral St., Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, or Town) (County) (State)		
BURIAL		4-11-68		Hillcrest		Annapolis A.A. Md.		
24 FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Phyllis M. Lytle		Annapolis, Md.		DATE APR 16 1968		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05117

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) FRANK		First		Middle		Last		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month 4 Day 7 Year 68		2b HOUR A.M.	
3 SEX M	4 RACE W	5 DATE OF BIRTH 12/24/10		6 AGE (In years and day) 57 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0		F UNDER 24 HRS HOURS 0 MIN 0		2c DATE PRONOUNCED DEAD Month 4 Day 7 Year 68		2d HOUR A.M.
7a BIRTHPLACE (State or foreign country) Penna.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH A.A.Co. Md					
10 CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NORTH. ARUNDEL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Eng.			12b KIND OF BUSINESS OR INDUSTRY Armco Steel		
13a USUAL RESIDENCE (Where deceased lived, if institution adm ssion) STATE MD			13b COUNTY AA CO.			13c CITY OR TOWN		3d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 203 MOUNTAIN RD.	
14. FATHER'S NAME First ? Middle Miller Last ?			15 MOTHER'S MAIDEN NAME First Ann Middle ? Last ?								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16b SOCIAL SECURITY NO. 205-05-2011			17 INFORMANT Mrs Mabel I Thomas			ADDRESS Same		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4127 Arteriosclerosis C.D.S. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4221											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		County State
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Not Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE E. Linhardt			EXAMINER'S NAME (Type) E. Linhardt			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED 4-7-68 AA CO.		
23a BURIAL CREMATION, REMOVAL (Specify) Burial			23b DATE 4/11/68			23c NAME OF CEMETERY OR CREMATORY Moreland Memorial Park			23d LOCATION (City or Town) Baltimore, Maryland (County) (State)		
24 FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland						25a RECEIVED BY REGISTRAR RRS 1968			25b RECEIVED BY REGISTRAR RRS 1968		



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

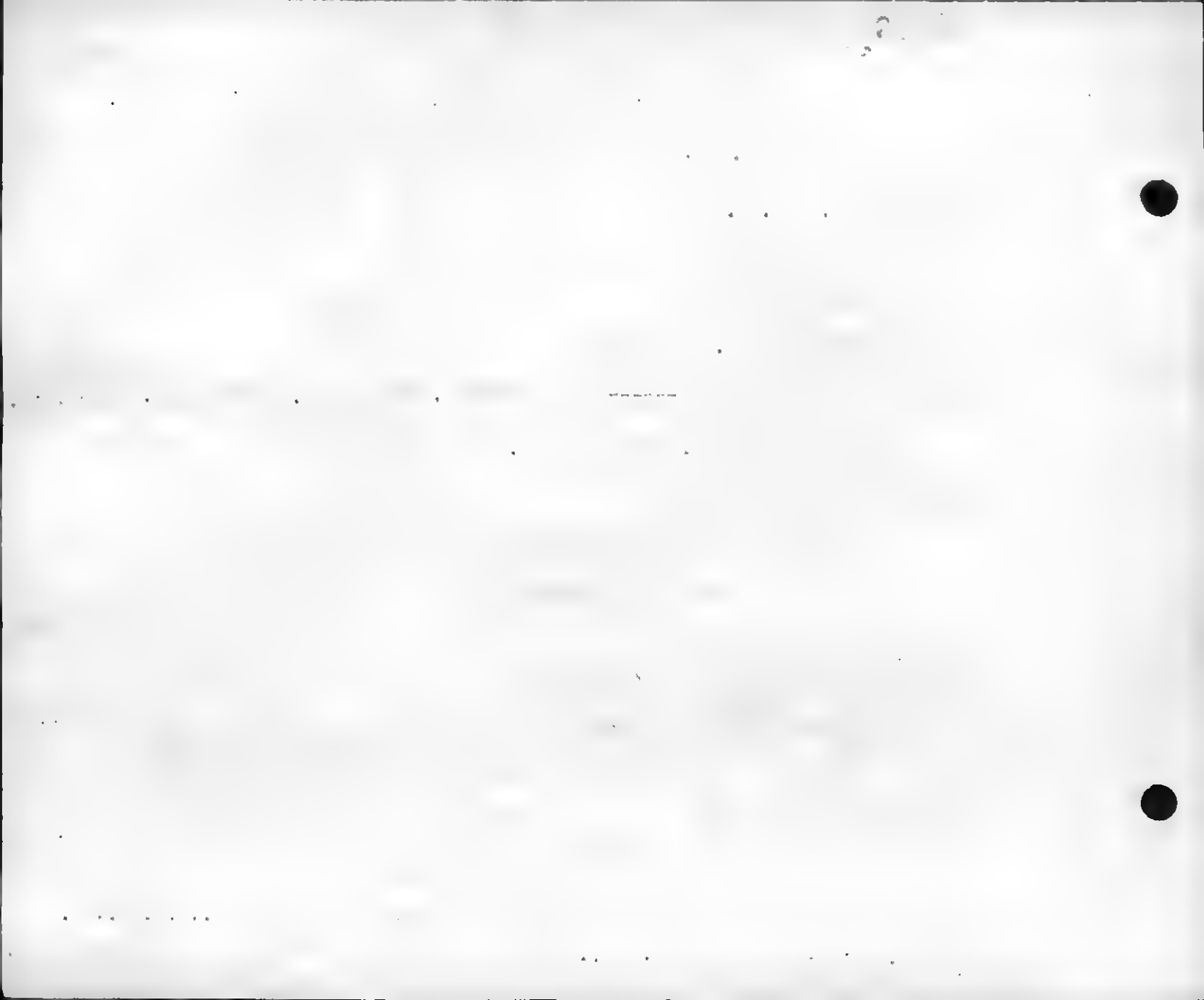
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05118

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) THOMAS J. MILLSAP			2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> 4 Day <input checked="" type="checkbox"/> 4 Year <input checked="" type="checkbox"/> 65			2b. HOUR P M					
3 SEX M	4 RACE CU	5 DATE OF BIRTH Oct. 17, 1964	6 AGE (In years last birthday) 3 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <input checked="" type="checkbox"/> 4 Day <input checked="" type="checkbox"/> 4 Year <input checked="" type="checkbox"/> 65			2d. HOUR P M		
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A.C.O.					
10. CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DDA-NORTH MARUNDEL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USLA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY A.A.C.O.		13c. CITY OR TOWN Pasadena		3d. INSIDE CITY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Del. Road Creek Dr			
14. FATHER'S NAME First THOMAS Middle R. Last Millsap			15. MOTHER'S MAIDEN NAME First Betty Anne Middle Cook Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. -----		17. INFORMANT Thomas R. Millsap-Rt. 11, Box 59H Pasadena, Md.			ADDRESS Colony Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 9109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a) 929.0											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input checked="" type="checkbox"/> P.M. <input checked="" type="checkbox"/> 4-4 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) Fell into dry well					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home - yard			21f. LOCATION Street or RFD No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE E. Lowman				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 4-4-68			
EXAMINER'S NAME (Type) E. Lowman				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town or county) A.A.C.O.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-8-1968		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park				23d. LOCATION (City or Town) Ritchie Hwy., A.A.C.O., Md.		(County) (State)	
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore				ADDRESS				25a. REC'D BY REG STRAP APR 8 - 1968		25b. DECEASED'S SIGNATURE Charles Judge	

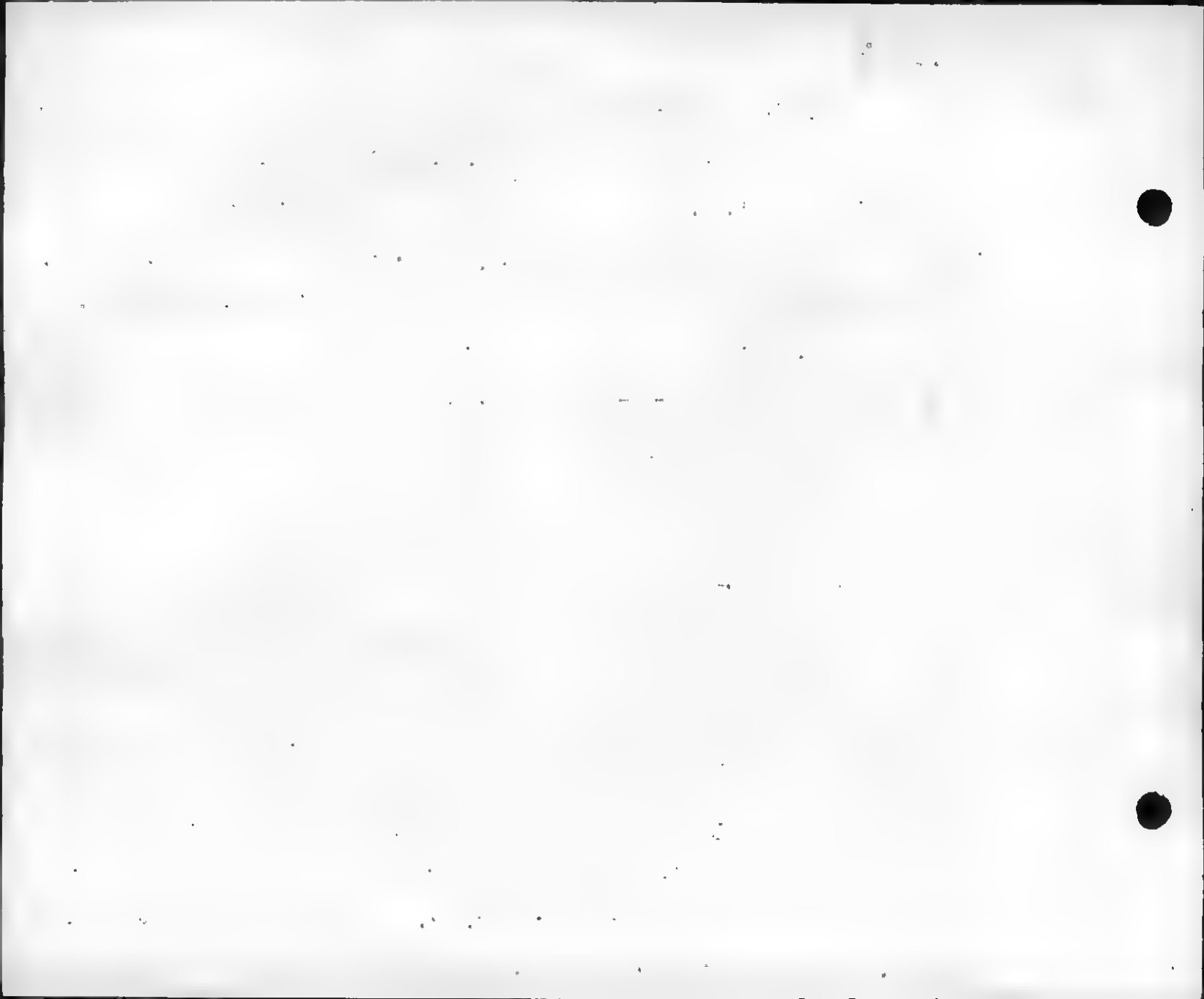


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) FREDERICK EUGENE MORRIS			2a. DATE OF DEATH Month 4 Day 22 Year 68			2b. HOUR 3⁰⁰ A M		
3 SEX Male		4. RACE White		5. DATE OF BIRTH Nov. 2, 1919		6. AGE (In years last birthday) 48 YRS.		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md		
10. CITY OR TOWN OF DEATH Pasadena			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1761 Poplar Ridge Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Maintenance		
12b. KIND OF BUSINESS OR INDUSTRY School Bd.			13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 1761 Poplar Ridge Rd.					
14. FATHER'S NAME First Middle Last Freddy T. Morris				15. MOTHER'S MAIDEN NAME First Middle Last Dora A. Nash				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 220-05-0358		17. INFORMANT Address Mrs. Margaret Morris Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1621 CACHEXIA								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1957 , 19____, to APRIL , 19 68 , that (I) (we) last saw the deceased alive on APRIL 10 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Arthur Lankford Jr. M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED 4-22-68		
22d. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR. M.D.						22e. ADDRESS 2934 MOUNTAIN RD PASADENA, MD 21122		
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE April 24, 1968		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland A. A. Co		
24. FUNERAL DIRECTOR ADDRESS George J. Gonce 4001 Ritchie Hwy. Balto. 21225				25a. REC'D BY REGISTRAR APR 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

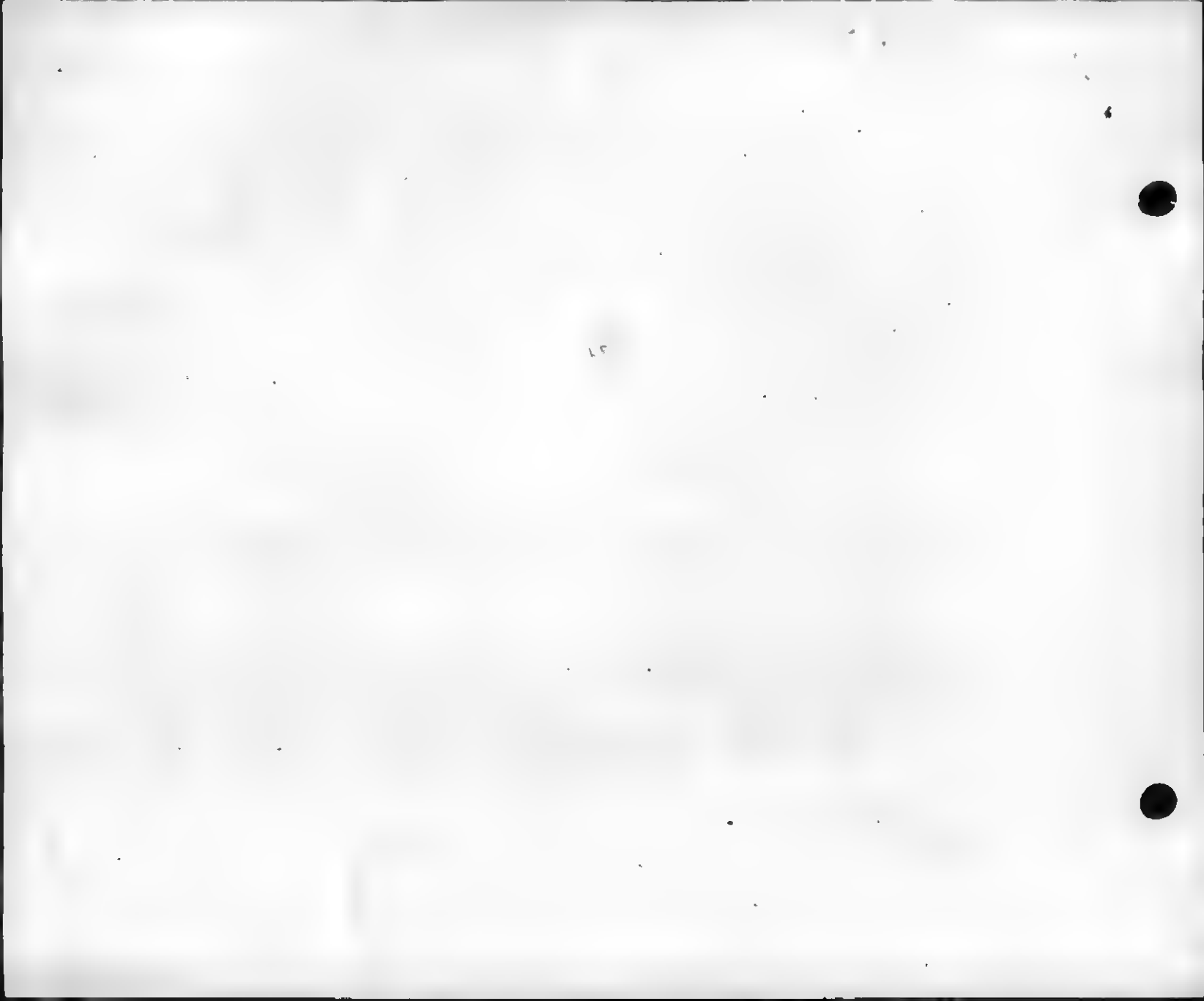
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05120

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) First: <u>Michael</u> Middle: <u>T</u> Last: <u>MOUNTAIN</u>			2a DATE KNOWN OF DEATH Month: <u>4</u> Day: <u>8</u> Year: <u>1968</u>			2b HOUR <u>A</u> M				
3 SEX <u>M</u>	4 RACE <u>W</u>	5 DATE OF BIRTH <u>Apr. 12-1950</u>	6 AGE (In years last birthday) <u>17</u> YRS	IF UNDER 1 YEAR MONTHS: _____ DAYS: _____	IF UNDER 24 HRS HOURS: _____ MIN: _____	2c DATE PRONOUNCED DEAD Month: <u>4</u> Day: <u>8</u> Year: <u>1968</u>			2d HOUR <u>A</u> M	
7a BIRTHPLACE (State or foreign country) <u>Bethesda Md</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>A.A. CO.</u>				
10 CITY OR TOWN OF DEATH <u>Glen Burnie</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>NOAH ARUNDEL - D.O.A.</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Marine</u>			12b KIND OF BUSINESS OR INDUSTRY <u>U.S.M.C.</u>		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Maryland</u>			13b COUNTY <u>Anne Arundel</u>		13c CITY OR TOWN <u>Glen Burnie</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <u>#105 Dinwiddie Ave</u>	
14. FATHER'S NAME First: <u>Charles</u> Middle: <u>T.</u> Last: <u>Mountain</u>			15. MOTHER'S MAIDEN NAME First: <u>Lois</u> Middle: <u>M.</u> Last: <u>Rephogle</u>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>			16b SOCIAL SECURITY NO <u>Active Duty unknown</u>		17. INFORMANT <u>MRS. Lois M. Mountain</u>			ADDRESS <u>brother same as #13</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>multiple injuries</u> 815.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Seconds</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>819.4</u>										
19a. DATE OF OPERATION <u>4/11/68</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR <u>4</u> AM <u>4</u> PM <u>8</u> 19 <u>68</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Auto accident - Car struck fence post</u>					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Highway</u>		21f LOCATION Street or RFD No. City or Town County State <u>Andover + W. Nursery Rd - P.H.C. + D</u>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>E. Linhardt</u>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <u>4/18/68</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county) <u>P.H.C.</u>				
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE <u>4/11/68</u>		23c NAME OF CEMETERY OR CREMATORY <u>Baltimore North Cemetery</u>			23d LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>			
24. FUNERAL DIRECTOR <u>E.B. Fleming</u>				ADDRESS <u>Singleton Funeral Home Glen Burnie, Md</u>		25a REC'D BY REG STRAR <u>APR 9 - 1968</u>		25b REG STRAR'S SIGNATURE <u>John Charles Judge</u>		



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VR A11141
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05121

1 DECEASED NAME (Type or print) Florence			First Middle Last			2a DATE OF DEATH Month Day Year April 11 1968			2b. HOUR A.M. 4:20 M		
3. SEX Female			4. RACE Caucas			5 DATE OF BIRTH 4/33/1917			6. AGE (In years last birthday) 50 YRS		
7a 8 RTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Anne Arundel Md.		
10 CITY OR TOWN OF DEATH Annapolis			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Naval Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None			12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Calvert			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 418 Chester Ave.			14 FATHER'S NAME First Middle Last James Andrew			15 MOTHER'S MAIDEN NAME First Middle Last Mary Margaret					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 214-552454			17. INFORMANT Dr. Charles W. Kinzer			Address 418 Chester Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, hemorrhagic DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, severe DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day many years many years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pituitary & adrenal cortical adenomas, Hypertension											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No City or Town County State					
22a I certify that (I) (the physician) attended the deceased from September 16 66 to April 11, 1968 , that (I) for last saw the deceased alive on April 10 , 1968, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (aid) (did not) view the body after death											
22b SIGNATURE Charles W. Kinzer						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED April 11, 1968		
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M.D.						22e. ADDRESS 16 Murray Ave., Annapolis, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 4/15/68			23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran			23d. LOCATION (City or Town) (County) (State) Annapolis D.C. Md.		
24 FUNERAL DIRECTOR William J. J. J. J.						25a REG. REGISTRAR APR 15 1968					

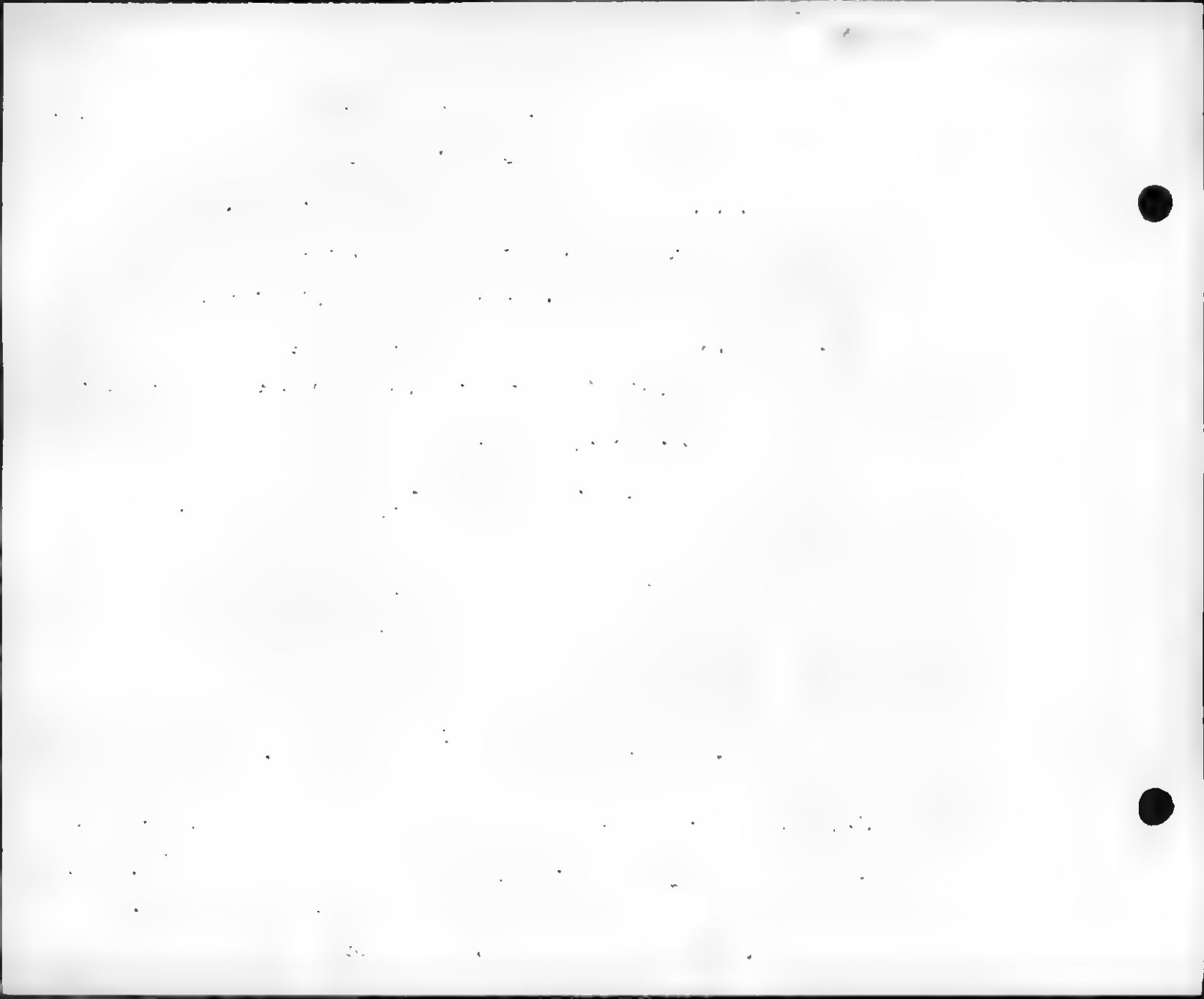


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30A REV. 1-68

05122												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH																							
1. OCCASION-NAME (Type or print) PAUL First F. Middle NEWTON Last						2a. DATE OF DEATH Month 5 , Day 1968 Year						2b. HOUR 6:40 AM											
3 SEX Male				4 RACE White				5. DATE OF BIRTH September 5, 1881				6 AGE (In years last birthday) 86 YRS				IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		MIN			
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Anne Arundel Md											
10 CITY OR TOWN OF DEATH Glen Burnie				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel Conv. Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired				12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Lansdowne				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 206 Mine Bank Lane									
14. FATHER'S NAME First William Middle Newton Last						15. MOTHER'S MAIDEN NAME First Sarah Middle Stewart Last																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO. 705-03-9369				17. INFORMANT Mrs. Mary R. Colburn				Address 206 Mine Bank Lane											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Guinea (c) stroke - vascular accident												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Urinary tract infection																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. col. examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)															
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)				21f. LOCATION Street or R.F.D. No City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from 3/17 , 19 68 , to 4/5 , 19 68 , that (I) (we) last saw the deceased alive on 4/5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE B. A. de Guzman DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED 4/6/68											
22d. PHYSICIAN'S NAME (Type) B. A. de GUZMAN, M.D.												22e. ADDRESS 335 HOSPITAL PL. BALTIMORE, MD. 21061											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 4-8-1968				23c. NAME OF CEMETERY OR CREMATORY Western Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland											
24. FUNERAL DIRECTOR Howard H. Hubbard						ADDRESS 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR 10		25b. REGISTRAR'S SIGNATURE Charles Judge													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 1 1968											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M		
Julie			Ann			Nicholson			April 20 1968 2020		
3. SEX Female			4. RACE Cauc			5. DATE OF BIRTH 17 July 1966			6. AGE (In years last birthday) YRS. 21 MONTHS 21 DAYS HOURS MN		
7a. BIRTHPLACE (State or foreign country) Zanesville, Ohio			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arrundal Md.		
10. CITY OR TOWN OF DEATH EGGM, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kimbrough Army Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Child			12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Anne Arrundal			13c. CITY OR TOWN EGGM			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Jerry Carl Nicholson			15. MOTHER'S MAIDEN NAME First Middle Last Jean Susan Stockdale			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No N/A			16b. SOCIAL SECURITY NO N/A		
17. INFORMANT Address Rt 2, Box 33 Ceder Dr. Severn, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Deferred Until Microscopic Section</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypoglycemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac Arrest</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8-9 Hrs.					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Deferred		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 20 April, 1968, to 20 April, 1968, that (I) (we) last saw the deceased alive on 20 April, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert F. Cullen, M.D.						22c. DATE SIGNED 21 Apr 68					
22d. PHYSICIAN'S NAME (Type) Robert F. Cullen, CPA, MC						22e. ADDRESS Kimbrough Army Hospital, Maryland 20755					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 24 Apr 68			23c. NAME OF CEMETERY OR CREMATORY Memorial Park			23d. LOCATION (City or Town) (County) (State) Zanesville Ohio		
24. FUNERAL DIRECTOR ADDRESS MIDWAY FUNERAL Home Glen Burnie Md.						25a. REC'D BY REGISTRAR DATE APR 23 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

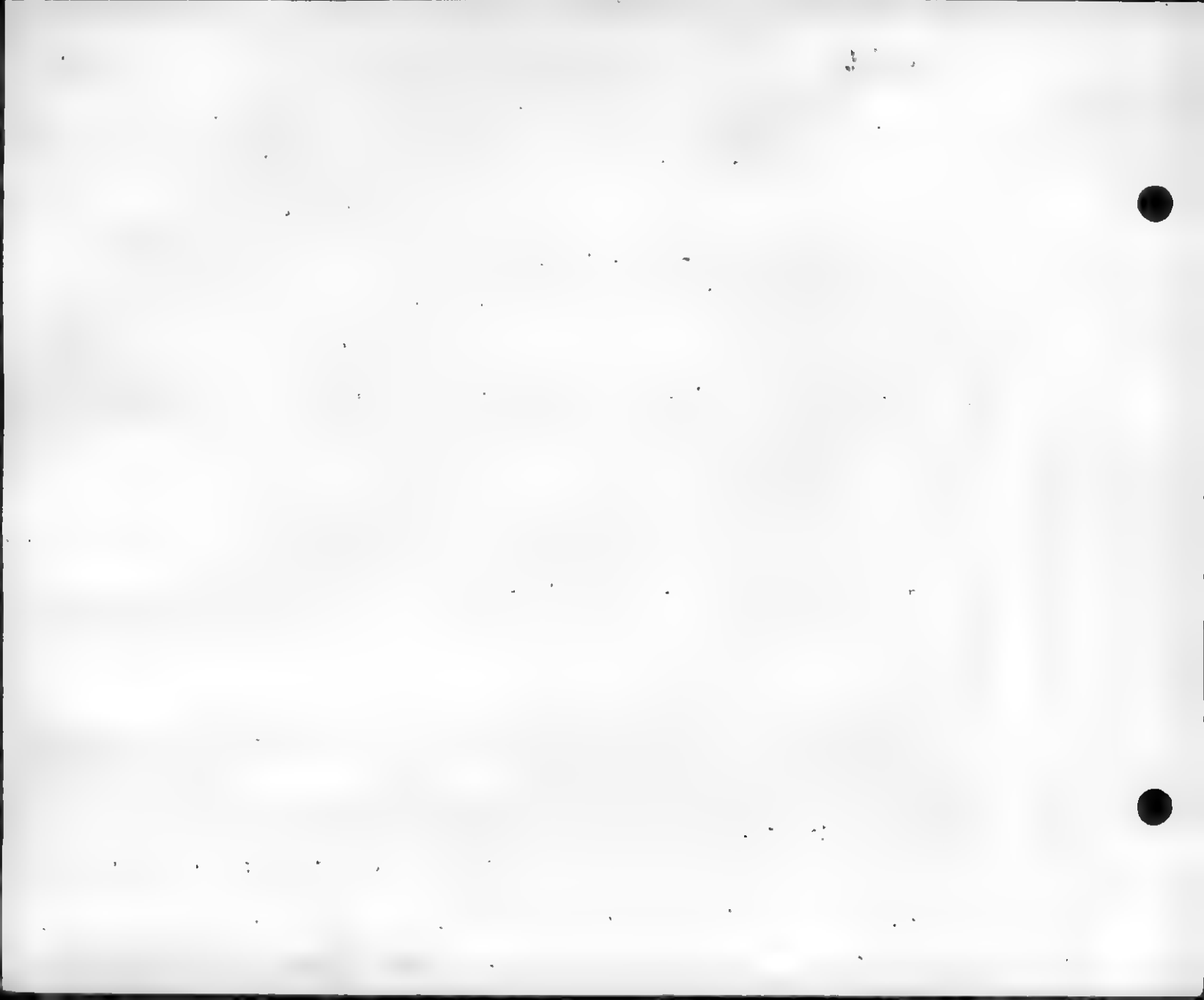


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Mitchell			Nolton			4/30 68		8:40am	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
Male		Negro		6/6/14		53 YRS			
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
GA.		USA				Anne Arundel			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USIA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Crownsville		Crownsville State Hospital		None					
13a. US.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		YES		NO		927 N. Caroline Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Fred Nolton			Mattie Mathis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		412-10-4922		Hospital Records, Crownsville Maryland					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute lymphoblastic leukemia</u> <u>204.0</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>207.3</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Anemia, Thrombocytopenia; Diabetes mellitus ; LIVER ABSCESSSES.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> , 19 <u>68</u> , to <u>4/30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>L. Benedict</u>		4/30/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
L. Benedict, M.D.		Crownsville State Hospital, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		5-4-68		MT AUBURN		BALTIMORE MD			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JOSEPH KNIGHT		1639 N. BROADWAY		MAY 2 1968		Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

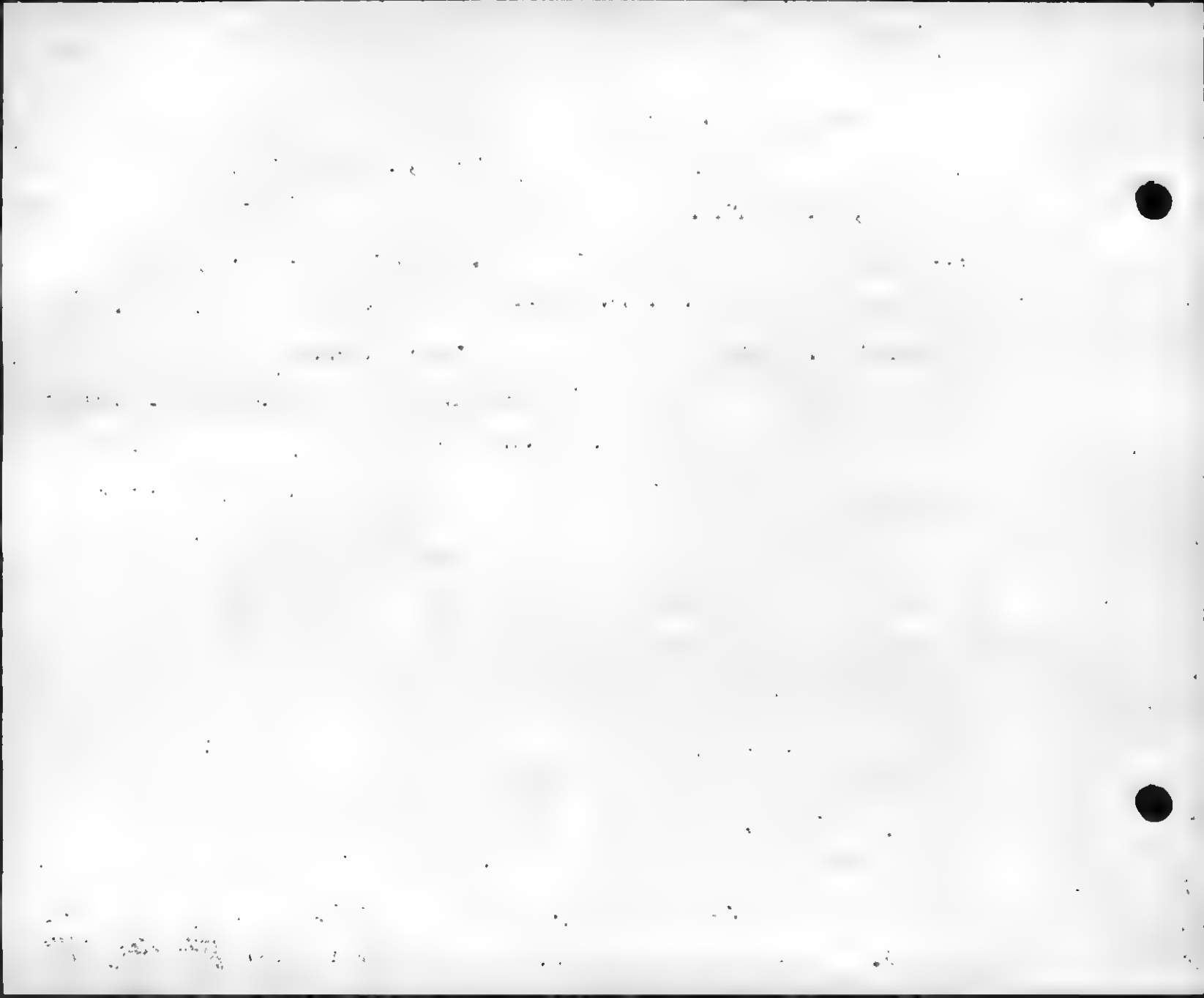
05125

129

1 DECEASED-NAME (Type or print) CHARLES W. NOVAK			2a. DATE OF DEATH Month 4 Day 11 Year 68			2b. HOUR 11 P M							
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JULY 12, 1912		6. AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0			
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md							
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FITTER (SHIP YARD)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admiss on) STATE MARYLAND			13b. COUNTY A. A. Co.			13c. CITY OR TOWN PASADENA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 7766 LAWRENCE AVE.	
14. FATHER'S NAME First CHARLES Middle J. Last NOVAK				15. MOTHER'S MAIDEN NAME First FLORENCE Middle COURSEY Last 									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address JULIA A. NOVAK 7766 LAWRENCE AVE. PASADENA							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION SUDDEN DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC HEART DISEASE UNKNOWN DUE TO, OR AS A CONSEQUENCE OF (c) 													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDIT ON GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1967 , 19 1968 , to 1968 , that (I) (we) last saw the deceased alive on 4-11-68 , 19 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Arthur Lankford Jr. M.D.						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 4-12-68				
22d. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD, JR., M. D.						22e. ADDRESS 2934 Mountain Rd. Pasadena, Md 21122							
23a. BURIAL, CREMATON, REMOVAL (Specify)			23b. DATE 4/15/68			23c. NAME OF CEMETERY OR CREMATORY Holy Cross			23d. LOCATION (City or Town) (County) (State) Glen Burnie Md				
24. FUNERAL DIRECTOR McGilly						ADDRESS 130 E. Fort Ave.			25a. REC'D BY REGISTRAR DATE APR 16 1968			25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV 1-68

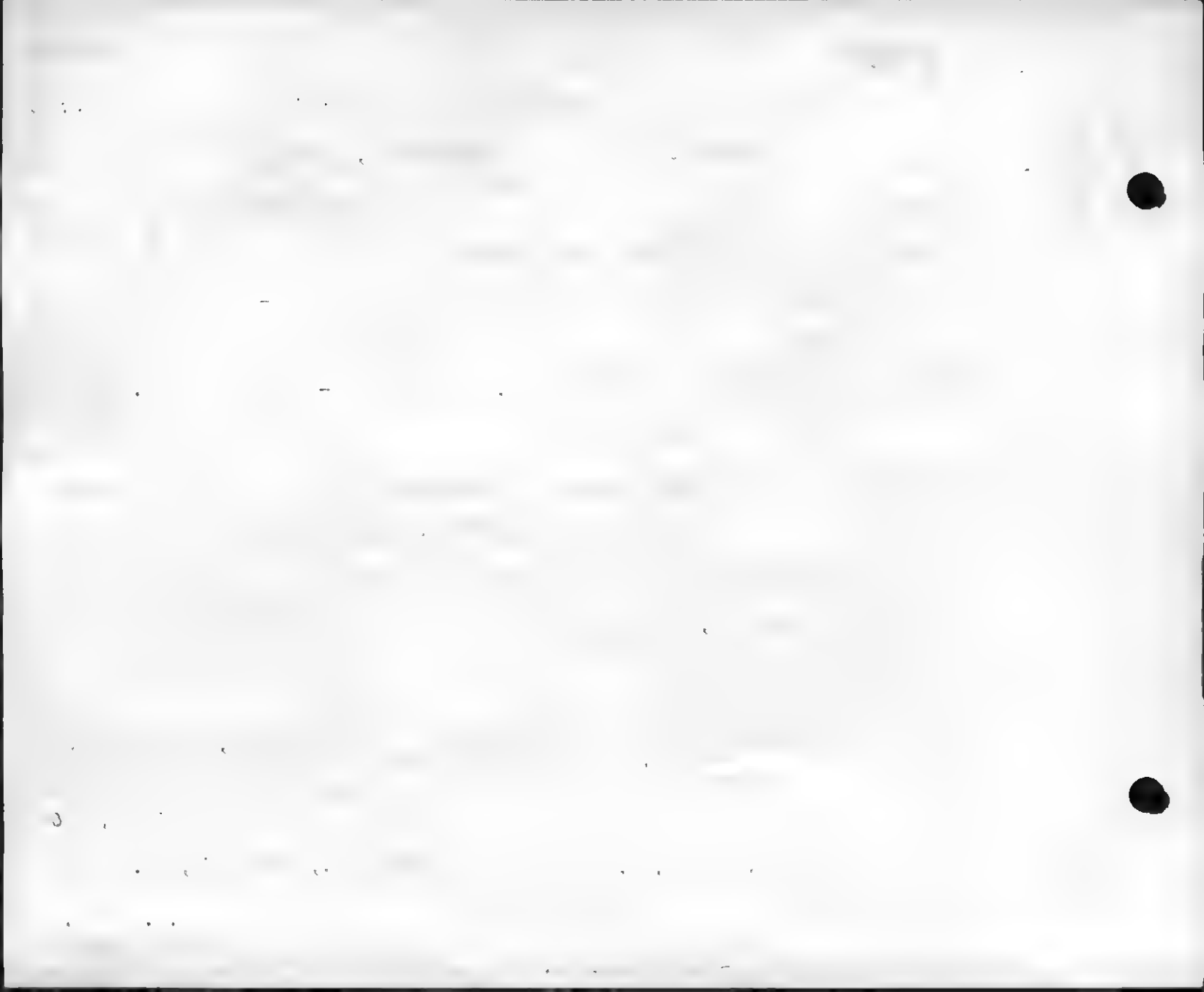
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05126

CERTIFICATE OF DEATH

151711

1. DECEASED-NAME (Type or print) August			First August			Middle NOWOTTNICK			Last			2a. DATE OF DEATH Month April Day 11 Year 1968			2b. HOUR 5:20 PM					
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH September 15, 1878			6. AGE (In years last birthday) 89 YRS			IF UNDER 1 YEAR MONTHS DAYS 			IF UNDER 24 HRS. HOURS MIN 					
7a. BIRTHPLACE (State or foreign country) Germany			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md											
10. CITY OR TOWN OF DEATH Millersville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Knollwood Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) retired farmer			12b. KIND OF BUSINESS OR INDUSTRY own farm											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Davidsonville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER --								
14. FATHER'S NAME First unknown			Middle unknown			Last unknown			15. MOTHER'S MAIDEN NAME First unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO 214-54-7705			17. INFORMANT Address Mrs. Emma Ecttner - Gambrills, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															(b) Chronic congestive heart failure			3 months		
DUE TO, OR AS A CONSEQUENCE OF															(c) Arteriosclerotic cardiovascular disease			many years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Anemia (due to epistaxis), Benign prostatic hypertrophy																				
19a. DATE OF OPERATION Jan 13, '68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cystoscopy, vesicle neck contracture			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NA											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State 														
22a. I certify that (I) person attended the deceased from February 4, 1968 , to April 11, 1968 , that (I) last saw the deceased alive on March 25, 1968 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) person (did not) view the body after death.																				
22b. SIGNATURE Charles W. Kinzer			DEGREE ATTENDING PHYS MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED April 12, 1968														
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.			22e. ADDRESS 16 Murray Ave., Annapolis, Md. 21401																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/15/68			23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery			23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.											
24. FUNERAL DIRECTOR Beverley E. Hopping			ADDRESS Hopping Funeral Home - Annapolis, Md.			25a. REC'D BY REGISTRAR DATE APR 17 1968			25b. REGISTRAR'S SIGNATURE Charles Judge											

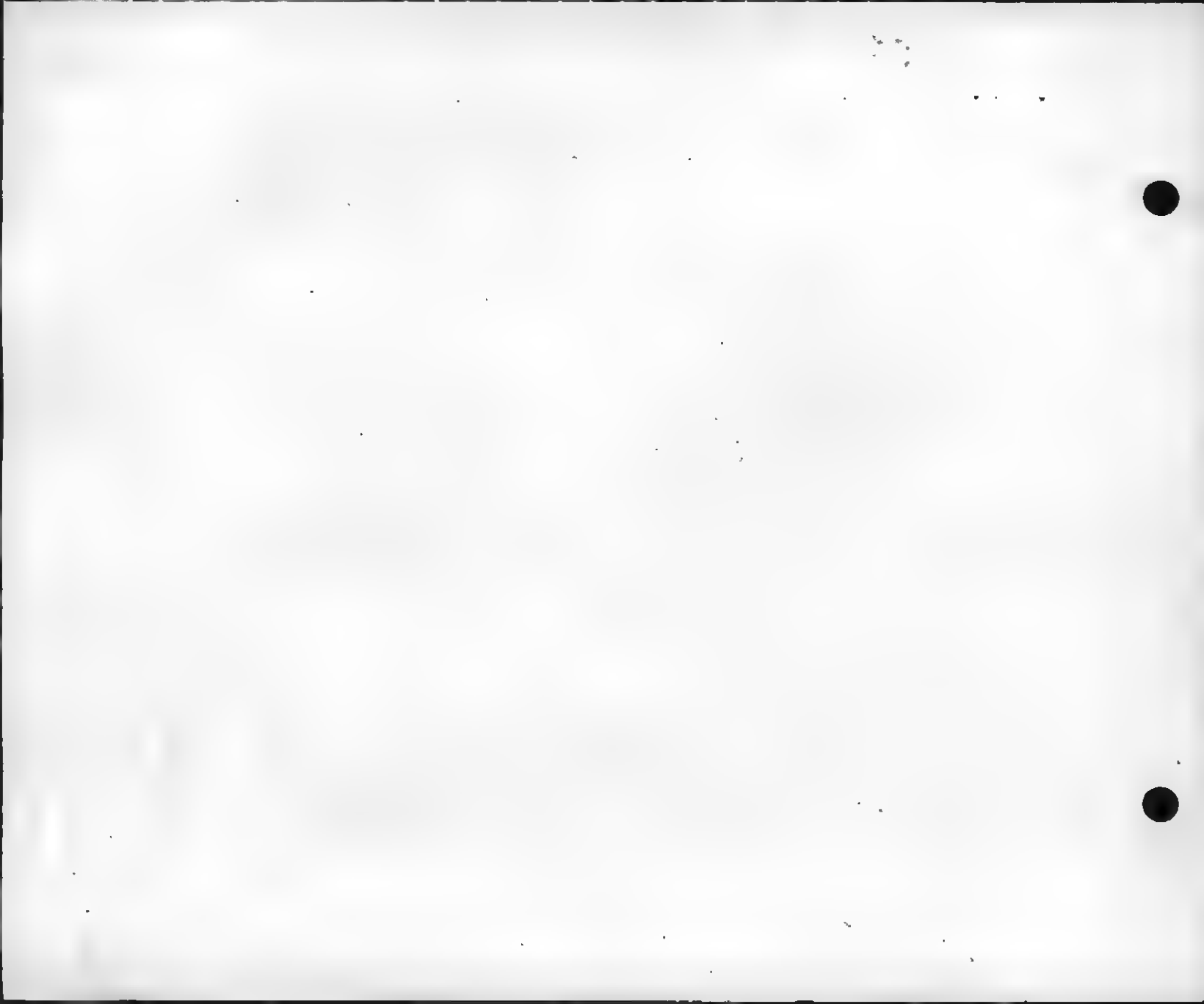


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year		2b HOUR
Amet (mmi) OSMAN						Month 4 Day 5 Year 68			A M		
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR
M	W	15 March 1894		74 YRS	MONTHS DAYS HOURS Min.				Month 4 Day 5 Year 68		A M
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Alabama			U.S.						A.H.CO.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			DOW-NORTH HAVEN								
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY, IN TS?		13e STREET AND NUMBER
MO			HACO			Glen Burnie			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Clark Harbor Road
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
(Unknown)			(Unknown)								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
Yes			1922-1946			Unknown			Mr. Ryland S. Massie (Friend) Same As #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19			20			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)								
			DUE TO, OR AS A CONSEQUENCE OF								
			(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
4221											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18)					
CAUSE OF DEATH			HOUR A.M. P.M.								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			4-5-68		
E. L. W. H. A. R. T						ADDRESS (Street, city, town, or county)			HACO		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			April 9, 1968			Arlington National Cem.			Fort Myer, Virginia		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
R. Singleton			Glen Burnie, Md.			APR 8 - 1968			Charles Judge		

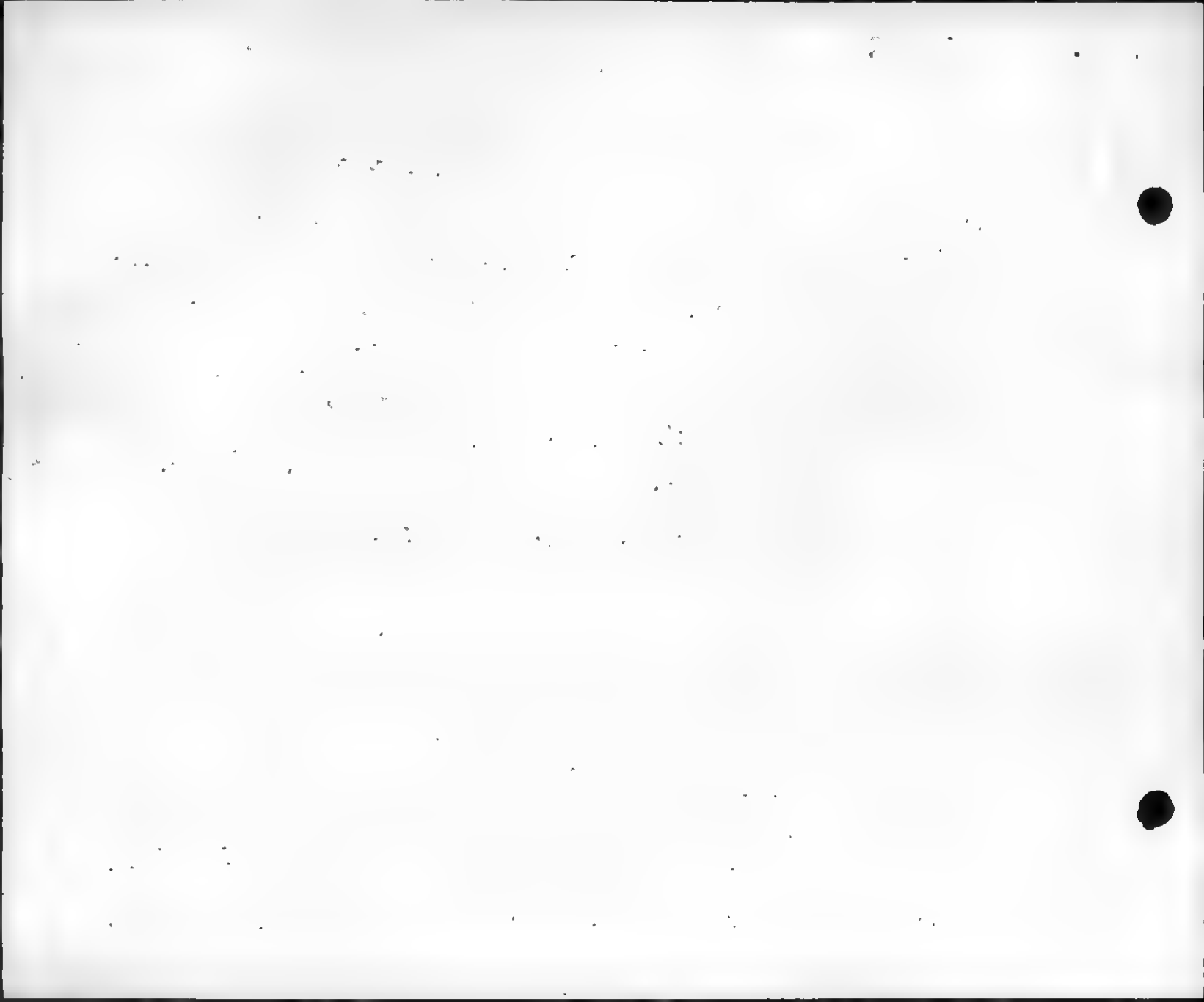


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2

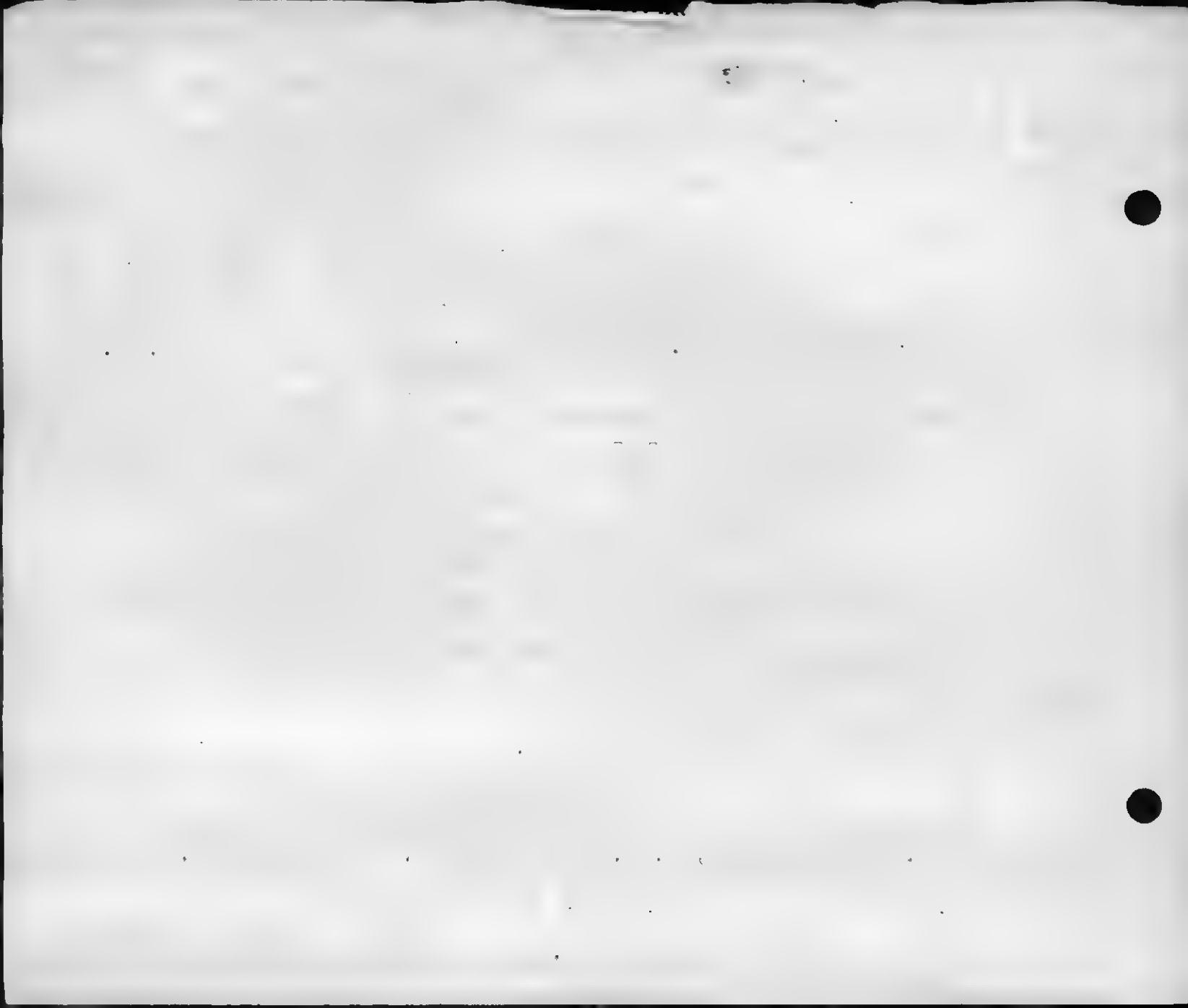
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
MAX			LOUIS			PASENKER			Month Day Year 3:08 P M APRIL 25 1968		
3 SEX		4 RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		JULY 20, 1928x				83 YRS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
RUSSIA			USA						ANNE ARUNDEL Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE			NORTH ARUNDEL GENERAL			RETIRED PROPRIETOR			LINOLEUM		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MARYLAND			ANNE ARUNDEL			GLEN BURNIE			215 KING GEORGE DRIVE		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
HARRY PASENKER			HELEN ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address MRS. HAZEL WILKES, XX 911 EDGERLY ROAD GLEN BURNIE, MD.					
NO											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>											
DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerotic Cardio-vascular dis.</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>hypertension</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis & senility</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>68</u> , to <u>4/25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>B. A. de Guzman</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. DATE SIGNED <u>4/25/68</u>											
22d. PHYSICIAN'S NAME (Type) <u>B. A. de GUZMAN M.D.</u> 22e. ADDRESS <u>325 HOSPITAL DR. GLEN BURNIE, MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		4-26-68		CEDAR PARK "BETH EL"		PARAMUS, NEW JERSEY					
24. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN ROAD, BALTO. 21215						25a. REC'D BY REGISTRAR DATE <u>APR 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5 63

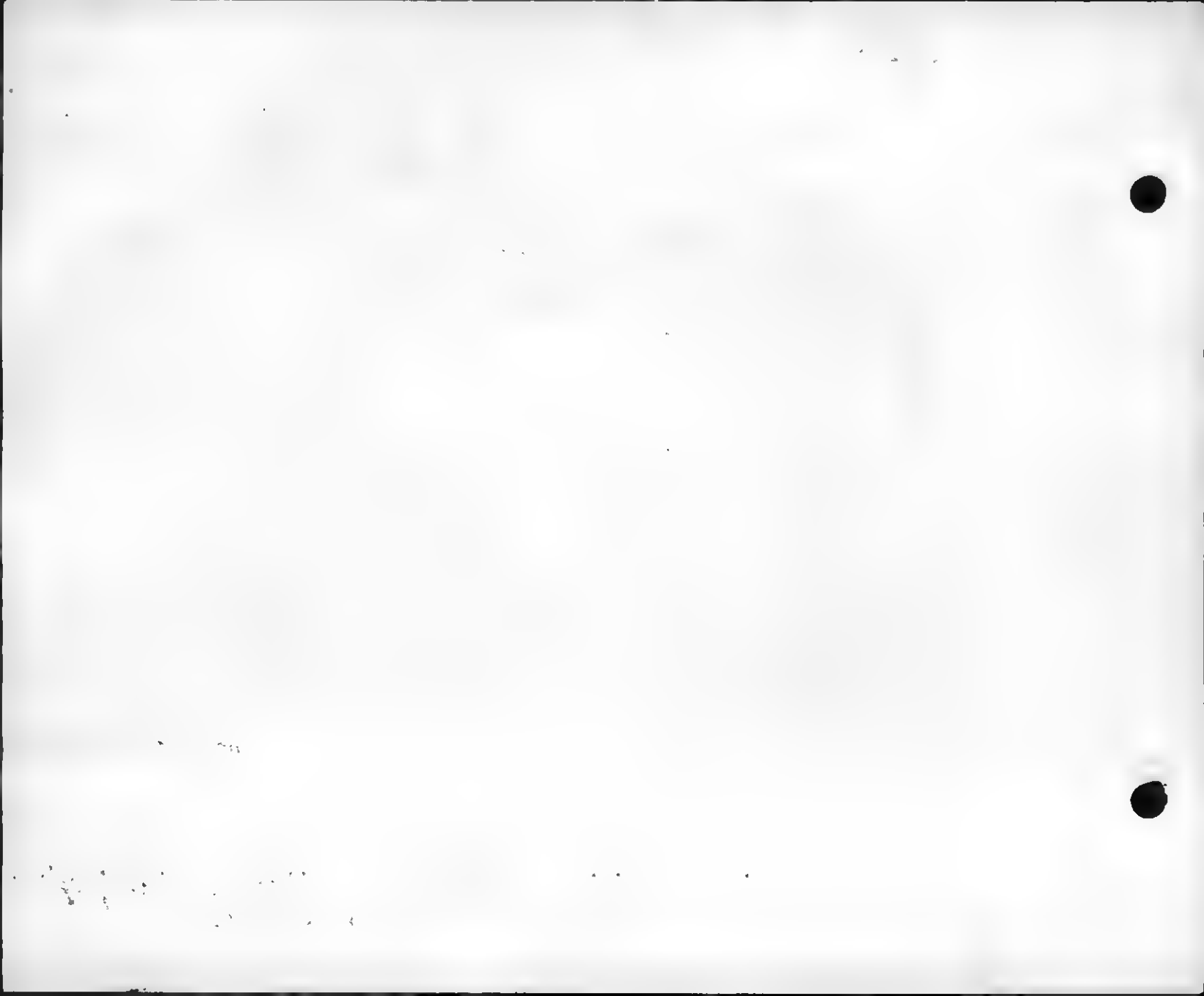
<div>Item 1-4-1</div> <div>6-128</div> <div>4-1</div>											
<div>Item 1-4-1</div> <div>6-128</div> <div>4-1</div>											
<div>Item 1-4-1</div> <div>6-128</div> <div>4-1</div>											
1. PLACE OF DEATH a. COUNTY Anne Arundle County MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6035 Ritchie Highway						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn d. STREET ADDRESS 6035 Ritchie Highway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) George Baker Phinney First Middle Last 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 2, 1913 9. AGE (In years last birthday) 54 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder 10b. KIND OF BUSINESS OR INDUSTRY Md. Dry Dock 11. BIRTHPLACE (County & State, or foreign country) Liberty, Kentucky 12. CITIZEN OF WHAT COUNTRY? U.S.A.						4. DATE OF DEATH April 29, 1968 Month Day Year IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.					
13. FATHER'S NAME Guy Phinney 14. MOTHER'S MAIDEN NAME Maude Coates 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes World War II 16. SOCIAL SECURITY NO. 222-10-3128 17. INFORMANT Mrs. Muriel L. Phinney-6035 Ritchie Hwy. Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> 185X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA LUNGS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1968 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 3/14 1968 to 4/29 1968, that (I) (we) last saw the deceased alive on 4/29 1968, and that death occurred at 4:45 P.M. from the causes and on the date stated above. 22a. SIGNATURE M.D. 22c. PHYSICIAN'S NAME (Type) J. Preston Grant, M. D. 22b. DATE SIGNED 4/29/68 22d. ADDRESS 601 N. Carrollton Ave. City 21217											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/3/68 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. 23d. LOCATION (City, town or county) (State) Baltimore, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Nutter-3005 N. North Ave. 25a. REC'D BY REGISTRAR DATE MAY 6 1968 25b. REGISTRAR'S SIGNATURE Charles Judge											



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon ~~pages~~ pages 1 and 2 — should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> 05130 MARYLAND STATE DEPARTMENT OF HEALTH </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR A.M.			
Caroline Harris Phipps						Month Day Year April 9 1968			3:40 M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
F		W		1-18-1929		39 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
GA.		U.S.				Anne Arundel Md						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis			H. H. GENERAL Hospt.			HOME			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MD.			A. A		Annapolis				Bywater Road			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
MARION Wilson Harris			FRANCES BROWN			LOVEJOY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
NO						Louis N. Phipps Jr.			#13E			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of breast with metastases</u>										4 mo.		
114X DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
11												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No			City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 4/18</u> , 19 <u>67</u> , to <u>4/9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE <u>Richard N. Peeler</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>4/5/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Richard N. Peeler, M.D.</u>						22e. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			4-11-68			CHESTERFIELD CENT.			CENTREVILLE QA. MD.			
24. FUNERAL DIRECTOR <u>John M. L. Loxton</u>						ADDRESS <u>Annapolis, Md.</u>			25a. REC'D BY REGISTRAR <u>APR 16 1968</u>			
									25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Mary EVELYN Piper						April Month 25 Day 1968			6 A.M.		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		white		April 24 1879		68 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
N. Carolina			USA				AA Co Md.				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
ANNAPOLIS				AA Gen Hosp				Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md				AA		Edgewater		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		OAKWOOD ROAD	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
JAKE OSBORNE			SARA HINES								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
Yes, no, or unknown						Raymond Piper			Edgewater, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction										Immediate	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease										year	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4701 Old compression fracture of T12 vertebrae; nephrosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1968, to April 25, 1968, that (I) (we) last saw the deceased alive on April 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Willard F. Smith										4/25/68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Willard F. Smith MD						Shady Side, Maryland					
23a. BURIAL, CREMATION, R.F.M.O.V.A.L. (Specify)		23b. DATE		23c. NAME OF CEMETERY, OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		APRIL 27, 1968		Hillcrest		ANNAPOLIS		AA Co		Md	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hardesty Funeral Home						DATE APR 30 1968		Charles Judge			

MEDICAL CERTIFICATION



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MEDICAL CERTIFICATION

1 DECEASED-NAME (Type or print)				First	Middle	Last	2a DATE OF DEATH			2b. HOUR	
J. ALBERT						RETOWSKY	Month	Day	Year	10:30 AM	
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		F UNDER 24 HRS
MALE		CAUCASIAN		11-23-81			86 YRS		MONTHS		DAYS
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				ANNE ARUNDEL Md					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE			NORTH ARUNDEL CONV. CTR			Restaurant			Own Business		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
MARYLAND			-		BALTIMORE				1522 SHEFFIELD RD		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
RUDOLPH					RETOWSKY	ELIZABETH					KRAUTER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT					
no						III Carvel Beach Rd. 21226 Myrtle E. Broome, sister,					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Left ventricular failure										hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										year.	
(b) Generalized arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Intestinal obstruction											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. Month Day Year								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f LOCATION			City or Town		
						Street or R.F.D. No.			County		
						State					
22a. I certify that (I) (this hospital) attended the deceased from 1-20, 1968, to 4/16/68, that (I) (we) lost the deceased alive on 4/16/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c DATE SIGNED		
MC FRANK W						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			4/16/68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
						2505 SE Ritchie Hwy Glen Burnie					
23a. B. RIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County)
Burial			4/18/68		Woodlawn Cemetery			Baltimore, Md.			(State)
											21061
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
Schimunek Funeral Home, Inc.									DATE		
3331 Brehms Lane									APR 19 1968		
									25b. REGISTRAR'S SIGNATURE		
									Charles Judge		



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

05133

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <i>James</i>			First Middle Last <i>Rich Jr.</i>			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year <i>4 12 68</i>			2b HOUR <i>11 A</i>		
3 SEX <i>M</i>		4 RACE <i>W</i>		5 DATE OF BIRTH <i>6/17/22</i>		6 AGE (in years last birthday) <i>46.5 YRS</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b CITIZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>ANN. ARUNDEL</i>		
10 CITY OR TOWN OF DEATH <i>Glen Burnie</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>DOA - N. W. ARUNDEL</i>			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <i>SUPERVISOR</i>			12b KIND OF BUSINESS OR INDUSTRY <i>TRUCKING</i>		
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>			13b COUNTY <i>HARCO</i>			13c CITY OR TOWN <i>Glen Burnie</i>			13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
13e STREET AND NUMBER <i>108 RANGE Road.</i>			14 FATHER'S NAME First Middle Last <i>Walter Edward Rich</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Lucy Barnes</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>			16b. SOCIAL SECURITY NO. <i>220-07-5131</i>			17 INFORMANT <i>Dorothy Rich</i>			ADDRESS <i>108 RANGE Rd 21061</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>1211</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>E. Lin Hirsch</i>			EXAMINER'S NAME (Type) <i>E. Lin Hirsch</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>4/12/68</i>		
						ASS STANT MED. CAL. EXAMINER <input type="checkbox"/>					
						DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town or county) <i>BACO</i>					
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>April 16, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>			23d. LOCATION (City or Town) (County) (State) <i>Baltimore Maryland</i>		
24. FUNERAL DIRECTOR <i>KIRKLEY Funeral Home</i>			ADDRESS <i>441 COIN SE</i>			25a. REC'D BY REGISTRAR <i>APR 17 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



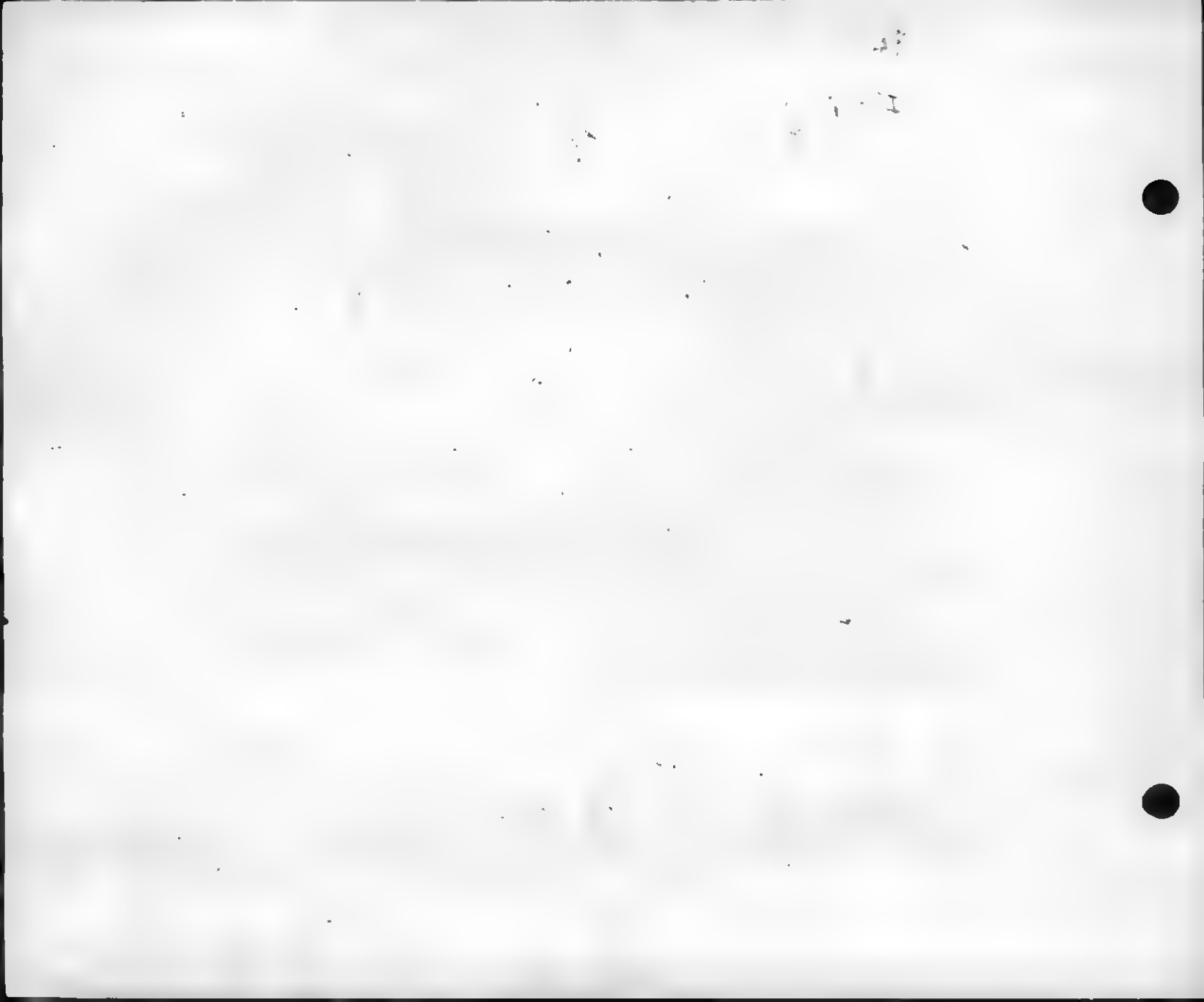
FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, or in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print) Irving			First Middle Last Richardson			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 4/2/1968			2b HOUR 11:30 AM		
3 SEX M		4 RACE N		5 DATE OF BIRTH 8/29/01		6 AGE 66 YRS		F UNDER 1 YEAR MONTHS - DAYS -		F UNDER 24 HRS HOURS - MIN -	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Anne Arundel		
10 CITY OR TOWN OF DEATH Severn, Md				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) P.O.A. at North Arundel				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Labourer		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md				13b COUNTY A.A.		13c CITY OR TOWN Severn		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Box 254	
14. FATHER'S NAME First Middle Last Wesley Richardson			15. MOTHER'S MAIDEN NAME First Middle Last Nancy Brown			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No			16b. SOCIAL SECURITY NO		
17 INFORMANT Patient's Chart, N.A.H. Emergency Room			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE HOUR					
B. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause 11/13/67 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Has been treated in past for a stroke											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles R. Wirth, MD				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 4/3/68			
EXAMINER'S NAME (Type) Charles H. Wirth, MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPT. MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town or county) Lothian, Md							
23a. BURIAL, CREMATION, OR REMOVAL (Specify)				23b. DATE 4-6-68		23c. NAME OF CEMETERY OR CREMATORY Int Calvary		23d. LOCATION (City or Town) (County) (State) Brooklyn A.A. Co Md			
24. FUNERAL DIRECTOR Turnell B. Alden - Balto, Md.				ADDRESS				25a. REC'D BY REGISTRAR APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05-135

Item 2 Film G399 4/20/68

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>ANN AP DL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DOE CT, MD</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route #175 & Mapes Road</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Texas</u> b. COUNTY <u>AYE AP MDL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>San Antonio</u> d. STREET ADDRESS <u>1911 Nolan Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>GIL RT</u> First Middle Last 4. DATE OF DEATH <u>April 13 1968</u> Month Day Year			5. SEX <u>Male</u> 6. COLOR OR RACE <u>Neg</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 5, 1915</u> 9. AGE (In years last birthday) <u>23</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SERVICEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. ARMY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>	
13. FATHER'S NAME <u>WILLIAM ROBERTS</u>		14. MOTHER'S MAIDEN NAME <u>WILLIE PAYNE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes-present 19Oct65-Present</u>		16. SOCIAL SECURITY NO. <u>49-74-7170</u>		17. INFORMANT <u>201 Personnel File, Ft Geo G. Meade, Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPHYXIATION</u> 8141 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASPIRATION OF BLOOD</u> DUE TO (c) <u>TRAUMA TO UPPER AIRWAY</u>				INTERVAL BETWEEN ONSET AND DEATH <u>INSTANTANEOUS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTRACRANIAL FRACTURE OF SKULL FRACTURE DUE TO TRAUMA</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Alleged that deceased was pedestrian struck by auto</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10:55 p.m.</u> <u>13 Apr 1968</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt #175 & Mapes Rd</u>	
				20f. (City or town) (County) (State) <u>Olenton, Anne Arundel Md.</u>	
21. I certify that (1) this hospital attended the deceased from <u>XXXXXX</u> to <u>XXXXXX</u> and that (2) the deceased <u>WAS DOA</u> <u>1968</u> , and that death occurred at <u>10:50</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Charles W. Yon, Capt MC (M.O.)</u>				22b. DATE SIGNED <u>14 Apr 68</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES W. YON MD</u>				22d. ADDRESS <u>KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem-Burial</u>		23b. DATE THEREOF <u>April 17 68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Jillett Cemetery</u>	
				23d. LOCATION (City, town or county) (State) <u>Jillett Texas</u>	
24. FUNERAL DIRECTOR <u>Harry H. Witzke, 321 Columbia Pike, Ellicott City, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>APR 22 1968</u>	
				25b. REGISTRAR'S SIGNATURE	



FOR STATE HEALTH DEPT.

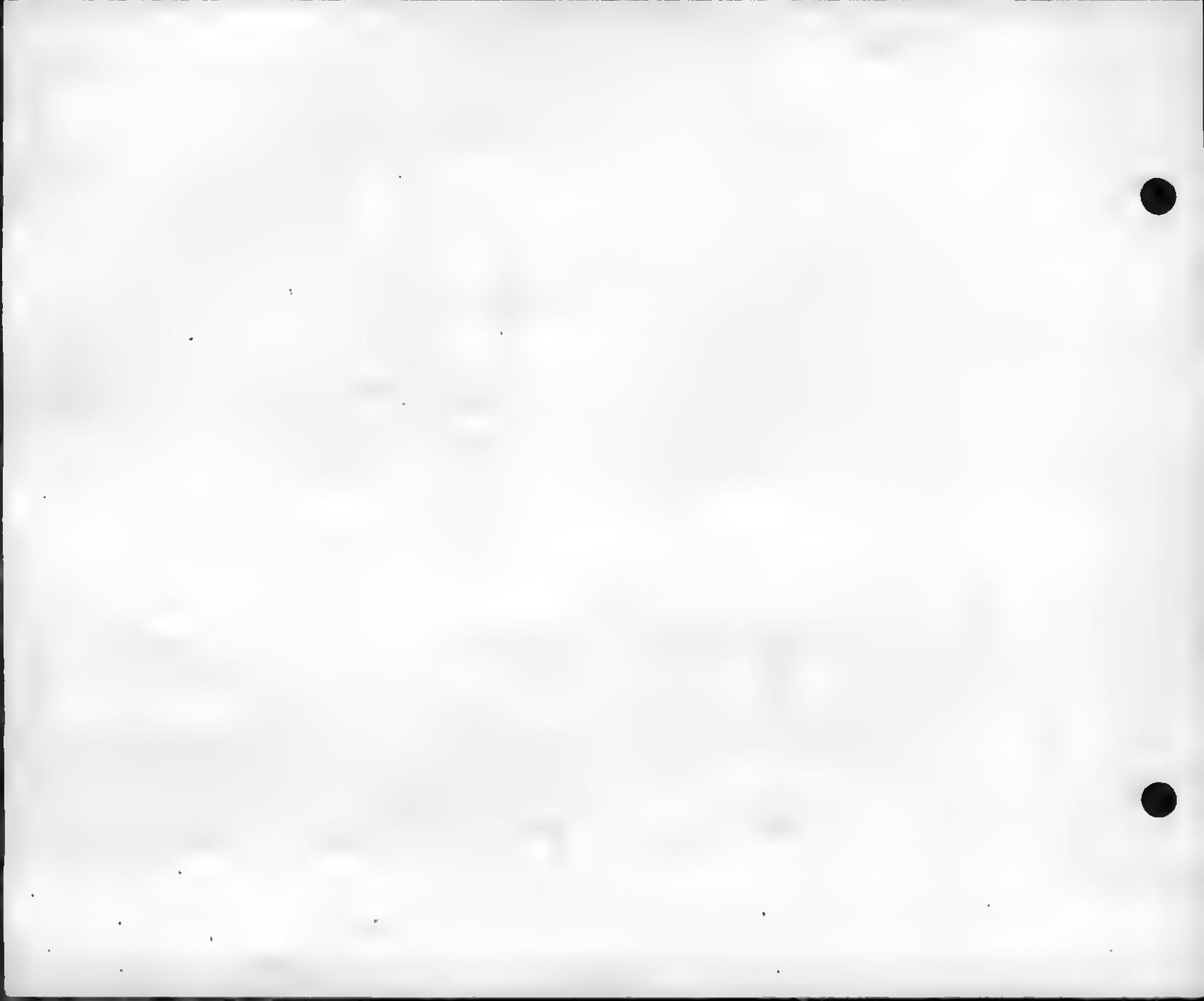
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05136

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) JAMES E. ROBINSON			2a DATE KNOWN OF DEATH Month 4 Day 20 Year 1968			2b HOUR 7 P.M.			
3 SEX M	4 RACE W	5 DATE OF BIRTH 5/30/45	6 AGE (In years last birthday) 22 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 4 Day 20 Year 1968			2d HOUR 7 P.M.
7a BIRTHPLACE (State or foreign country) Pa.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> D-VORCED <input type="checkbox"/>		9 COUNTY OF DEATH A.A.CO.			
1d CITY OR TOWN OF DEATH P.A.CO.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARBESS CREEK DR.			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) STUDENT			12b KIND OF BUSINESS OR INDUSTRY U. of MD.	
13a U.S.A. RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE MD		13b COUNTY AACO. CROWNSVILLE		13c CITY OR TOWN CROWNSVILLE		3a INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER BWELL-RL-2-	
14 FATHER'S NAME First ROBERT Middle H. Last ROBINSON			15. MOTHER'S MAIDEN NAME First ANNA E. Middle HANSHEN Last HANSHEN			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			
16b SOCIAL SECURITY NO no			17 INFORMANT ROBERT H. ROBINSON			17 ADDRESS Box 466 CROWNSVILLE, MD.			
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shin Shin Hand Stuck DUE TO, OR AS A CONSEQUENCE OF 755X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) Scalp.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 176X									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 4-20 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Self-inflicted gunshot wound				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Sweet or R.F.D. No		City or Town		County AACO	State MD
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE E. Linhardt			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 4-20-68			
EXAMINER'S NAME (Type) E. Linhardt			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) A.A.CO.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-24-68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) (County) (State) Hennepolis A.A. MD.			
24. FUNERAL DIRECTOR John M. Lipton Sons Annapolis, Md.			25a. REC'D BY REGISTRAR DATE APR 24 1968			25b. REGISTRAR'S SIGNATURE Charles Jones			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <i>Ralph</i>			First Middle Last <i>ROUZIE</i>			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>4</i> Day <i>7</i> Year <i>1968</i>			2b HOUR <i>P</i> M		
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>9-18-1906</i>	6 AGE (in years last birthday) <i>61</i> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month <i>4</i> Day <i>7</i> Year <i>1968</i>			2d HOUR <i>A</i> M
7a BIRTHPLACE (State or foreign country) <i>VA.</i>		7b C.T.ZEN. OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>A.A.C.O.</i>					
10 CITY OR TOWN OF DEATH <i>Glen Burnie</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>D.O.A. - Mr. B. BRUNDEL</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>MD</i>			13b COUNTY <i>HARCO</i>		13c CITY OR TOWN <i>Glen Burnie</i>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <i>Hampton Road. 708</i>		
14 FATHER'S NAME <i>Robert B. Rouzie</i>			First Middle Last <i>SR</i>			15 MOTHER'S M.A.DEN. NAME <i>Lucy</i>			First Middle Last <i>EDWARDS</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>			16b SOCIAL SECURITY NO <i>226-14-1016</i>			17 INFORMANT <i>VERA J. Rouzie</i>			ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>arteriosclerotic - c.v. disease</i> 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Insulin</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. <i>19</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (At home farm street factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>E. Linhardt</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <i>4-4-68</i>		
EXAMINER'S NAME (Type) <i>E. Linhardt</i>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street city town, or county) <i>A.A.C.O.</i>					
23a BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>			23b DATE <i>6 APR. 68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Essex Cemetery</i>			23d LOCATION (City or Town) (County) (State) <i>Essex Co. VA.</i>			
24 FUNERAL DIRECTOR <i>KIRKLEY Funeral Home, Md.</i>			ADDRESS <i>Glen Burnie</i>			120 REC'D BY REGISTRAR <i>APR 8 - 1968</i>			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

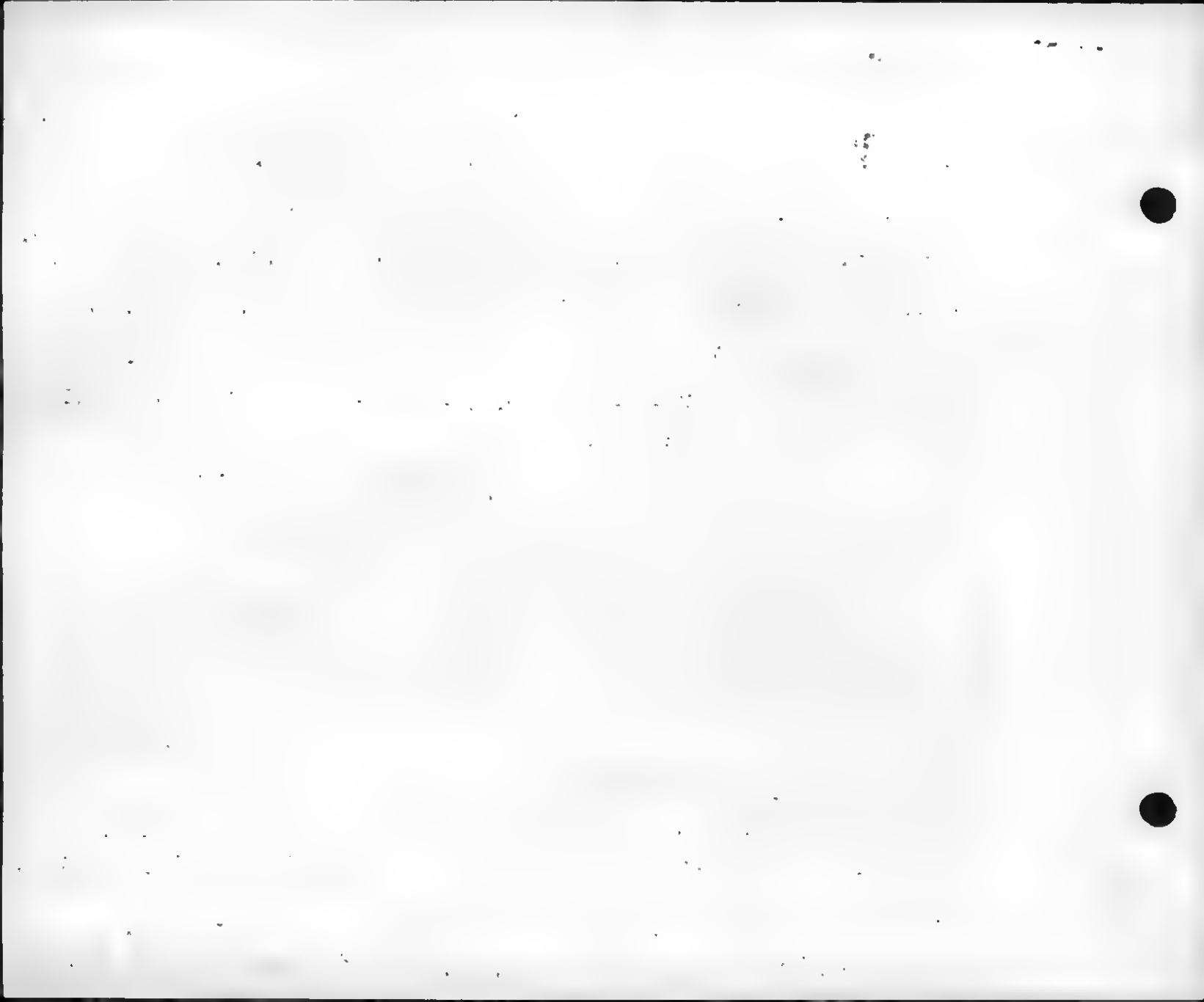


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 138
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) CS CR		First CS Middle CR Last CR		2a. DATE OF DEATH Month April Day 30 Year 1968		2b. HOUR 1:25 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 1869		6. AGE (In years last birthday) 78 YRS.	
7a. BIRTHPLACE (State or foreign country) Harrisburg, Ill.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 311 Wilson Blvd S/W		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Coal Miner (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY Peabody Coal Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First (unknown) Middle (unknown) Last (unknown)		15. MOTHER'S MAIDEN NAME First (unknown) Middle (unknown) Last Bush		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) None		16b. SOCIAL SECURITY NO 346-07-8699	
17. INFORMANT Mr. Charles E. Rude (Son)		Address Same as 13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Bronchogenic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) General pulmonary emphysema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from December 1967 to April 30, 1968 , that (I) (we) last saw the deceased alive on April 30, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. A. de Guzman		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/30/68	
22d. PHYSICIAN'S NAME (Type) B. A. de GUZMAN		22e. ADDRESS 335 HOSPITAL DR. GLEN BORNIE					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Sunset Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Harrisburg Ill	
24. FUNERAL DIRECTOR E. B. Fleming		ADDRESS Singleton Funeral Home		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE MAY 2 1968							



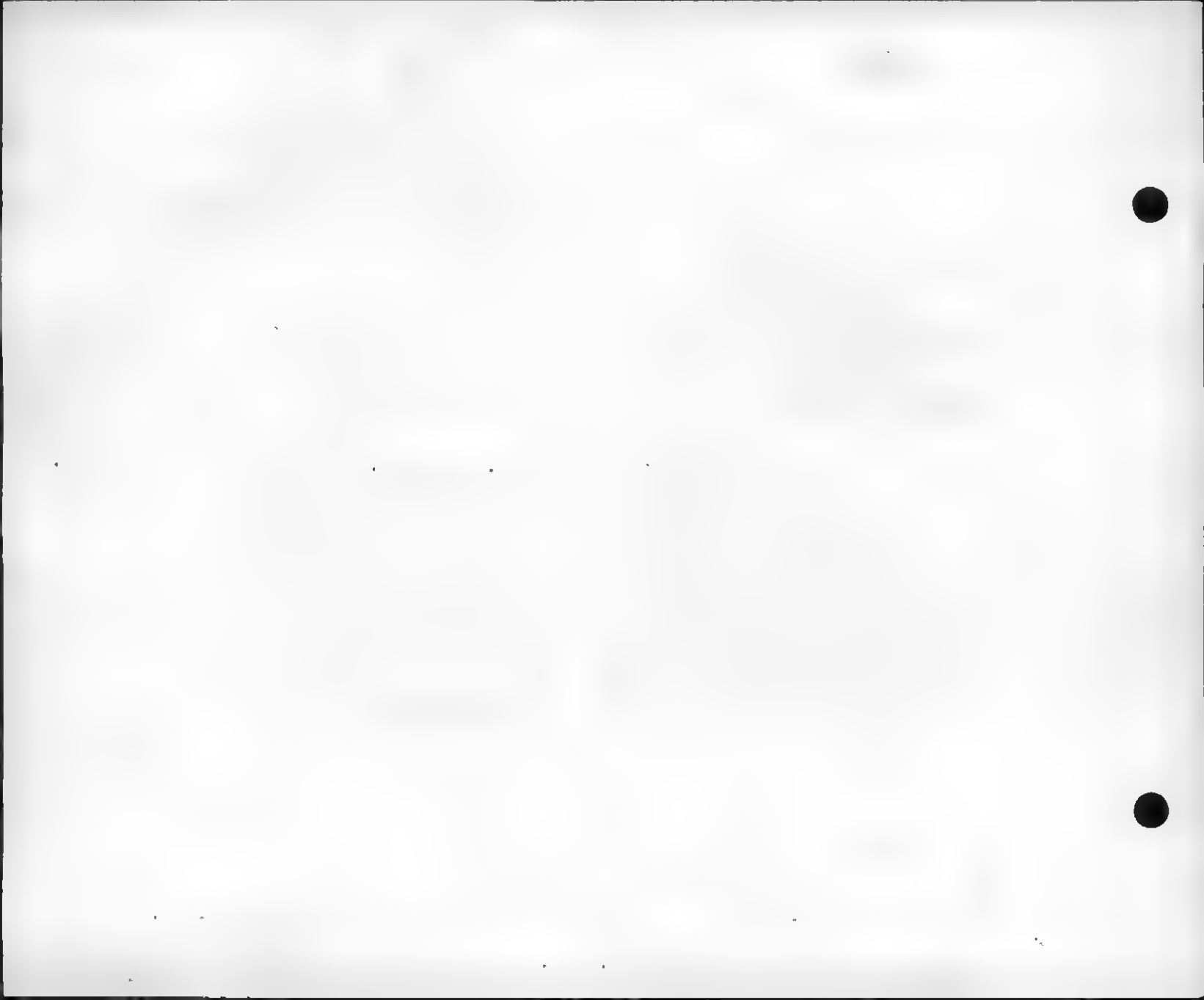
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnee</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>North Arundel Convalescent Home</i>		d. STREET ADDRESS <i>7 Cedar Point Rd.</i>	
3 NAME OF DECEASED (Type or print) <i>Arthur E. Sanders</i>		4 DATE OF DEATH Month <i>April</i> Day <i>3</i> Year <i>1968</i>	
5 SEX <i>Male</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>12-3-1897</i>
9 AGE (In years last birthday) <i>70 yrs</i>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13 FATHER'S NAME <i>George Sanders</i>		14 MOTHER'S MAIDEN NAME <i>Catherine (Bull) Sanders</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <i>217-01-0042</i>	
17 INFORMANT <i>Mrs. Edward A. Sanders</i>		Address <i>7 Cedar Point Road, Severna Park, Md.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <i>619</i> IMMEDIATE CAUSE (a) <i>CARCINOMA, Squamous cell, Rt vocal cord</i> DUE TO (b) <i>Arteriosclerosis, Cardiovascular disease</i> DUE TO (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>101X</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <i>1964</i> to <i>April 3</i> , 1968 that (I) (we) last saw the deceased alive on <i>April 28</i> , 1968, and that death occurred at <i>9:50 P.M.</i> from causes and on the date stated above			
22a SIGNATURE <i>Francis J. Coda</i>		22b DATE SIGNED <i>4-3-68</i>	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS <i>SEVERNA PARK MD</i>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
<i>Burial</i>	<i>4-5-68</i>	<i>Druid Ridge Cemetery</i>	<i>Pikesville, Md.</i>
24 FUNERAL DIRECTOR <i>4101 Edmondson Avenue</i> <i>Witzke Funeral Directors, Balto., Md. 21229</i>		25a REC'D BY REGISTRAR DATE <i>APR 5 - 1968</i>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

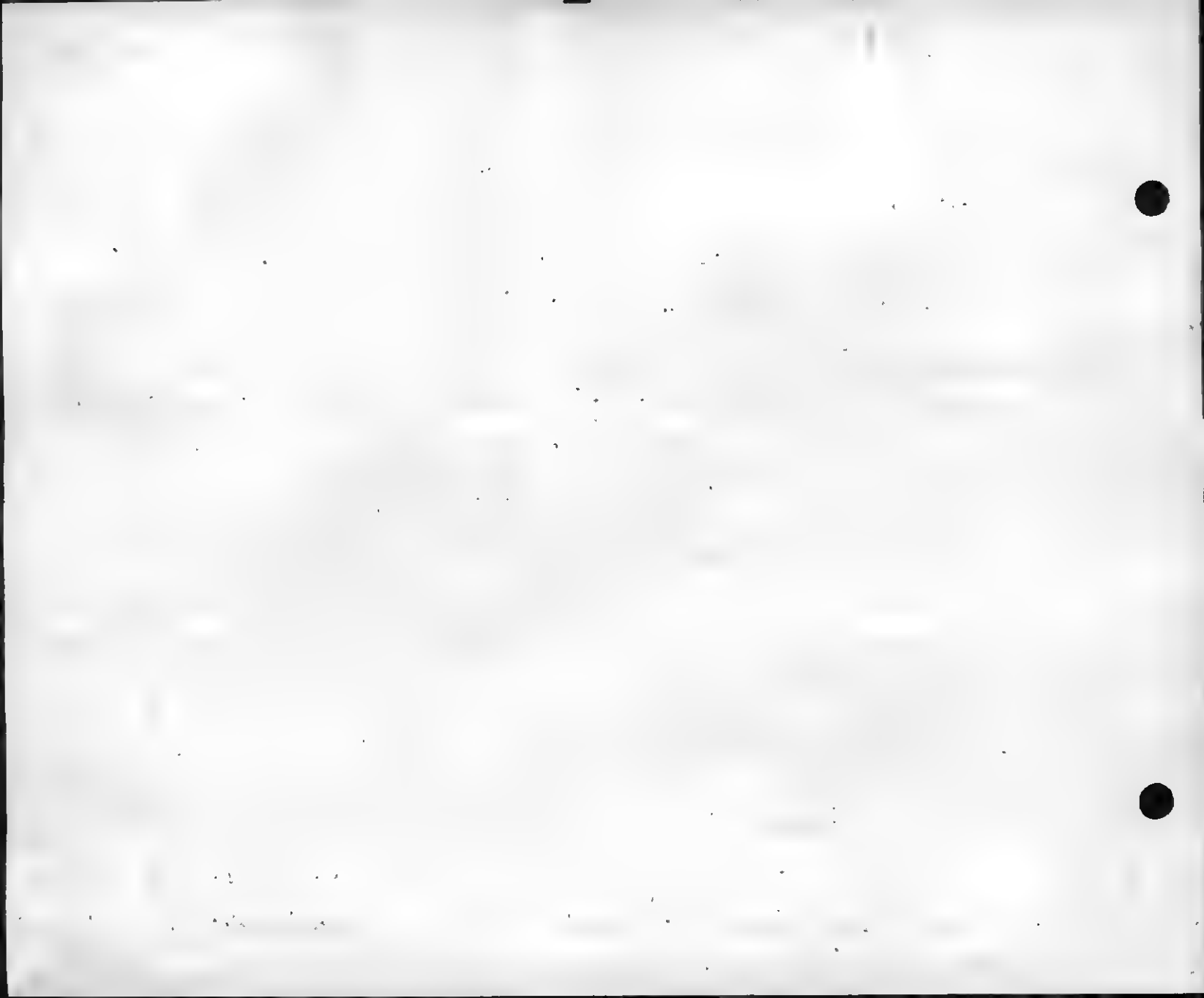


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Donna M Sawyer			2a. DATE OF DEATH Month 4 Day 7 Year 68			2b. HOUR 9:15p M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH 11/26/16		6. AGE (In years lost birthday) 51 YRS		IF UNDER 1 YEAR MONTHS 5 DAYS 10 HOURS 15 MIN	
7a. BIRTHPLACE (State or foreign country) Michigan		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Anne Arundel Md.			
10 CITY OR TOWN OF DEATH Crownsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 75 Summerhill park	
14 FATHER'S NAME First Fredrick Middle Einhardt Last Einhardt			15 MOTHER'S MAIDEN NAME First Eva Middle Einhardt Last Einhardt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 377-22-6143		17. INFORMANT Hospital Records, Crownsville State Hosp. Address					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4107 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) F.U.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 3/29 , 19 68 , to 4/7 , 19 68 , that (I) (we) lost saw the deceased alive on 4/7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L. Benedict, M.D.					DEGREE MD ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/8/68		
22d. PHYSICIAN'S NAME (Type) L. Benedict, M.D.					22e. ADDRESS Crownsville State Hosp. Crownsville, Md.				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 4-10-68		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN		23d. LOCATION (City or Town) (County) (State) GLEN BURWIE AA. MD.			
24. FUNERAL DIRECTOR John M. Layton Sons Annapolis, Md.					25a. REC'D BY REG. STRAR DATE APR 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

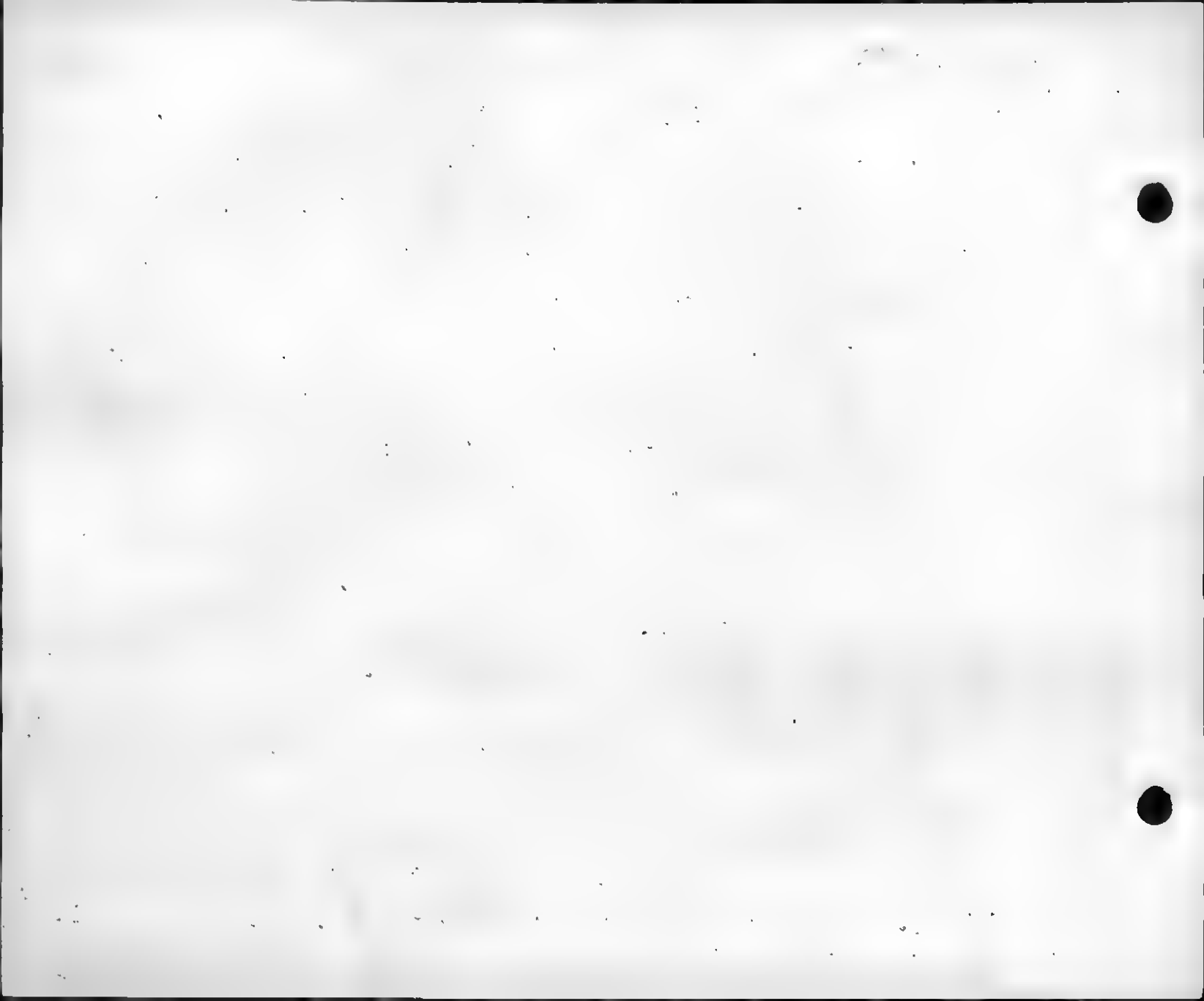


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

DECEASED-NAME (Type or print) SAMUEL COURTNEY SCHAMEL			First Middle Last		2a. DATE OF DEATH Month APRIL Day 13 Year 1968			2b. HOUR 2:45 A M			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 9/8/1885			6 AGE (In years last birthday) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md					
10. CITY OR TOWN OF DEATH CRUNNSVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) RR EMPLOYEE			12b. KIND OF BUSINESS OR INDUSTRY BALTO. TRANSIT		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MD			13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN MIKERSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 1-BOX 182 B		
14. FATHER'S NAME First Middle Last SAMUEL PETER SCHAMEL			15. MOTHER'S MAIDEN NAME First Middle Last SARAM UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 213-10-1541		17. INFORMANT MEDICAL HOSPITAL RECORDS Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MALNUTRITION & DEHYDRATION											
DUE TO, OR AS A CONSEQUENCE OF (b) C.B.S. AM. WITH SENILITY											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
ANTEROCHONTERIC FRACTURE OF R. HIP											
19a. DATE OF OPERATION 4/5/68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED HIP-FRACTURE			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify med. col. examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 4 P.M. 4 19 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) PATIENT FELL					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. DAYROOM			21f. LOCATION Street or R.F.D. No. City or Town County State CRUNNSVILLE STATE HOSPITAL A-A MD					
22a. I certify that (this hospital) attended the deceased from 4/12/68 , 19 68 , to 4/13/68 , 19 68 , that (I) (we) last saw the deceased alive on 4/13/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]			DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4/13/68					
22d. PHYSICIAN'S NAME (Type) L. BENEDICT M.D.			22e. ADDRESS CRUNNSVILLE STATE HOSPITAL								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4/16/68		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY			23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.			
24. FUNERAL DIRECTOR Robert P. [Signature]			ADDRESS Singleton Funeral Home Glen Burnie			25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge		
DATE APR 15 1968											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

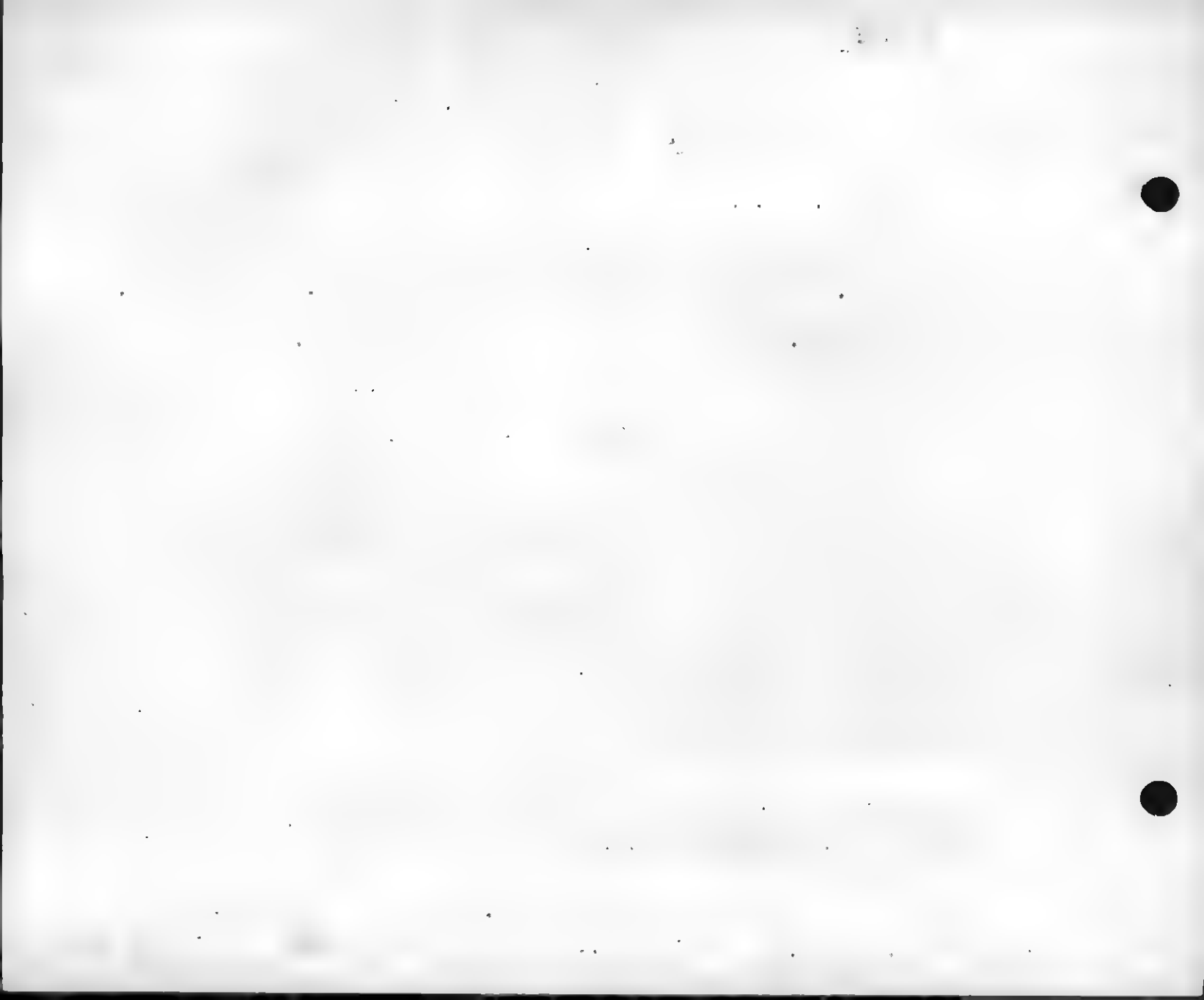


FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print) <i>Steven Allen Schuh</i>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <i>4</i> Day <i>14</i> Year <i>1968</i>			2b. HOUR <i>11</i> AM				
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>8-21-51</i>	6 AGE (in years last birthday) <i>16</i> YRS	7 UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	8 IF UNDER 24 HRS HOURS <i></i> MIN <i></i>	2c. DATE PRONOUNCED DEAD Month <i>4</i> Day <i>14</i> Year <i>1968</i>			2d. HOUR <i>10</i> AM	
7a. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel CO Md</i>				
10 CITY OR TOWN OF DEATH <i>glen Burnie</i>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>DC-A-NORTH ARUNDEL</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>School boy</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Anne Arundel</i>			13c. CITY OR TOWN <i>Pasadena</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>Rt. 6, Farm View Rd.</i>
14 FATHER'S NAME First <i>Alvin F.</i> Middle <i>Schuh</i> Last <i></i>				15 MOTHER'S MAIDEN NAME First <i>Ruby M.</i> Middle <i>Kahmer</i> Last <i></i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i></i>			17. INFORMANT <i>Alvin Schuh - same</i>				ADDRESS
18 CAUSE OF DEATH (Enter only one cause per Part 1. Death was CAUSED BY IMMEDIATE CAUSE (a) <i>multiple injuries</i> DUE TO, OR AS A CONSEQUENCE OF <i>16.7</i> Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i)										
19a. DATE OF OPERATION <i>4-15-68</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Auto accident -</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <i>PM 4/15 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Auto accident -</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>			21f. LOCATION Street or RFD No. <i>RL 177</i>		City or Town <i>NACU.</i> County <i>MD</i> State <i>MD</i>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>E. L. Linhardt</i>			EXAMINER'S NAME (Type) <i>E. L. Linhardt</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>4-14-68</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>4-17-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Park</i>			23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>		
24 FUNERAL DIRECTOR <i>George J. Gonce-4001 Ritchie Hwy., Baltimore</i>					25a. REC'D BY REGISTRAR <i>APR 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Carlos Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 11-1-64
30M REV 1-65

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Ethel</i> First Middle Last <i>Scott</i>		2a DATE OF DEATH Month <i>April</i> Day <i>12</i> Year <i>1968</i>		2b HOUR <i>5A</i> M
3 SEX <i>Female</i>	4 RACE <i>Negroe</i>	5 DATE OF BIRTH <i>6-12-1902</i>	6 AGE (In years last birthday) <i>65</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) <i>Md.</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>C.C.</i> Md	
10 CITY OR TOWN OF DEATH <i>Annapolis</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>U.S. General Hospital</i>	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Housewife</i>	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>	13b COUNTY <i>Ad.</i>	13c CITY OR TOWN <i>Shady Side</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER
14 FATHER'S NAME First Middle Last <i>Levi Gross</i>	15 MOTHER'S MAIDEN NAME First Middle Last <i>Susie Offer</i>	16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16b SOCIAL SECURITY NO.		17 INFORMANT <i>Henry B. Gross Shady Side Md.</i> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>+33.9</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>years</i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Osteoarthritis, urinary tract infection, diculbitous ulcer of spine</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>60</i> , to <i>April 12</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>April 11</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Willard F. Smith</i>	DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>4/12/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Willard F. Smith MD</i>	22e. ADDRESS <i>Shady Side, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>4-15-1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gross</i>	23d. LOCATION (City or Town) (County) (State) <i>Shady Side Md.</i>	
24. FUNERAL DIRECTOR <i>William Reese Jr.</i>	ADDRESS <i>Living Md.</i>	25a. REC'D BY REG. STRAR DATE <i>APR 15 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

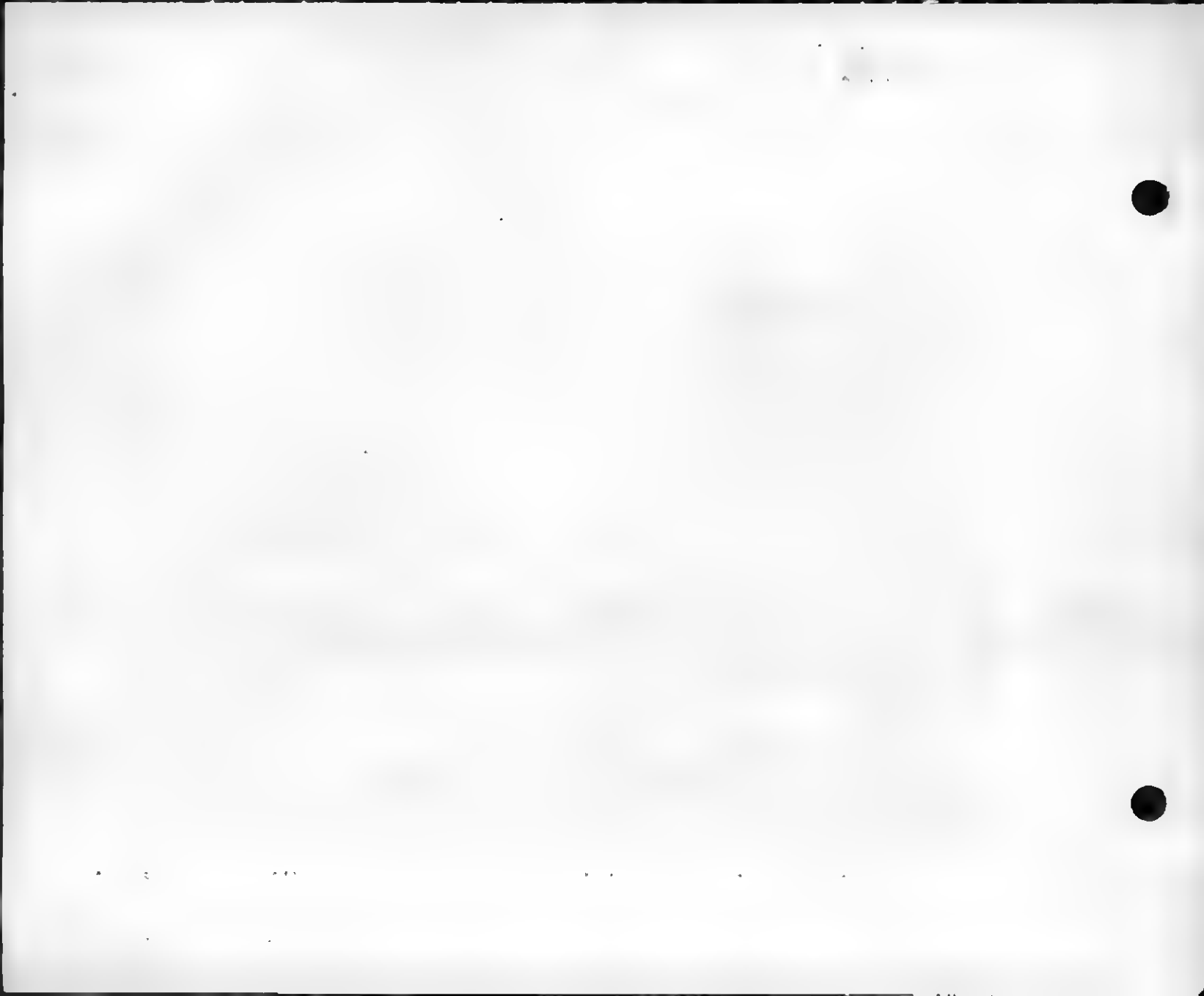
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Donald Warren SHARP			2a. DATE OF DEATH Month Day Year April 2 1968			2b. HOUR P 6:20 M	
3 SEX Male		4. RACE white		5. DATE OF BIRTH March 16 1917		6. AGE (In years last birthday) 51 YRS	
7a. BIRTHPLACE (State or foreign country) MONTANA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) AA General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY AN		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Edwin C. Sharp		15. MOTHER'S MAIDEN NAME First Middle Last Alice Burke					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO 23-14-2551		17. INFORMANT Address 1425 1/2 St. NE, Wash. D.C. 20004			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Sarcoma - 201X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 67		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (did not) attended the deceased from 12/6 , 19 67 , to 4/2 , 19 68 , that (I) (did not) saw the deceased alive on 4/2 , 19 68 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.							
22b. SIGNATURE Richard N. Peeler				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/3/68	
22d. PHYSICIAN'S NAME (Type) Richard N. Peeler, M.D.				22e. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 4/3/68		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD	
24. FUNERAL DIRECTOR Funeral Home, Annapolis, Md.				ADDRESS		25. REC'D BY REGISTRAR DATE APR 4 - 1968	
				25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

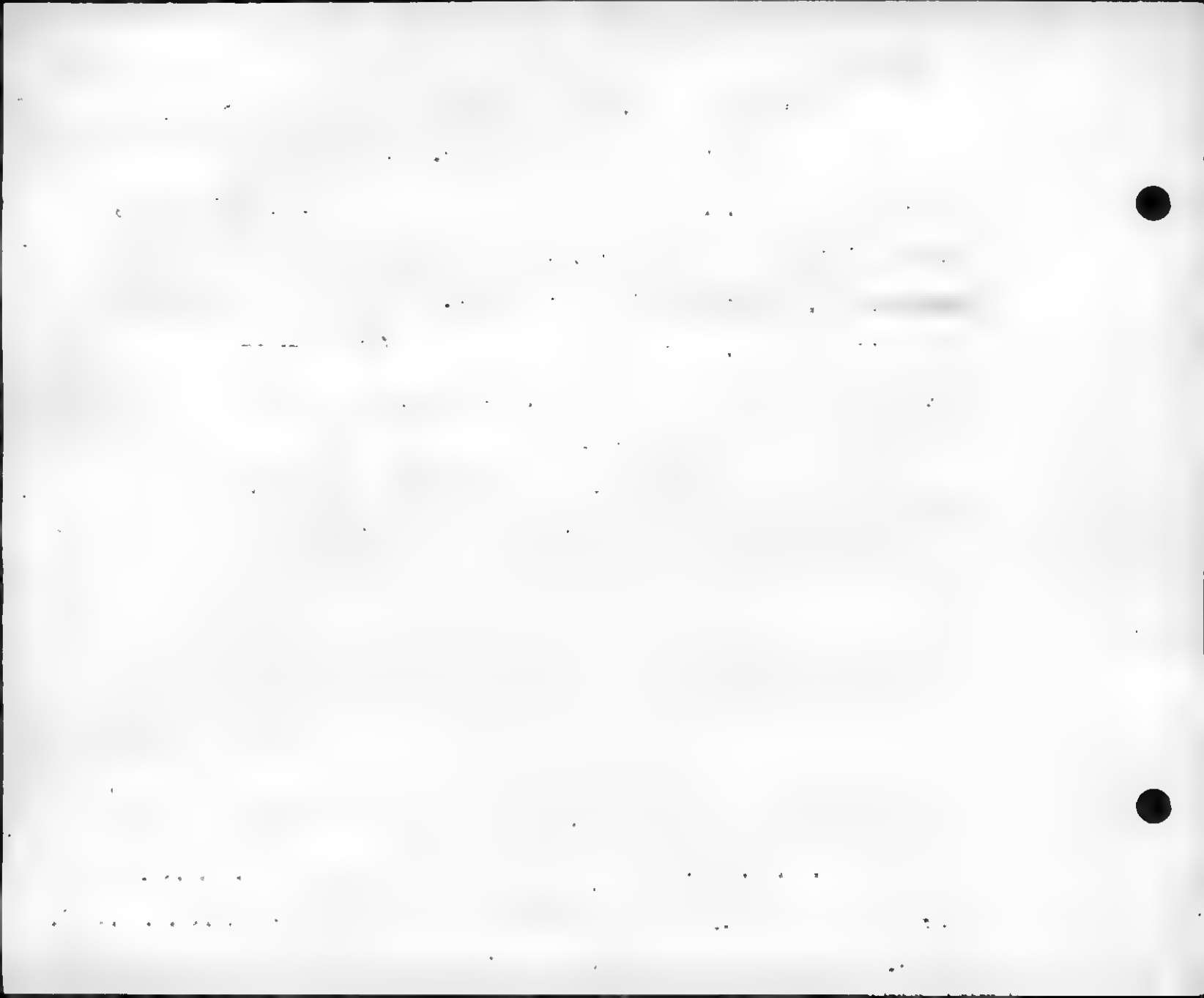
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VR A15 (4)
30M REV 1/68

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
BENJAMIN F. SHECKELS						April 25, 1968			3:45 A		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (n years last birthday)		7 UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Dec. 26, 1891		76 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
Maryland		U.S.				Anne Arundel County, Md			Aircraft Parts		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					
Brooklyn Park			311 Seward Avenue			Office Manager					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Anne Arundel			Brooklyn Pk.			311 Seward Avenue		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
William J. Sheckels			Mary								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No						S. Maude Sheckels - same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO OR AS A CONSEQUENCE OF (b) <i>Generalized Metastatic Carcinoma</i> DUE TO OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>1 1/2 yrs.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/26</i> , 19 <i>67</i> , to <i>4/25</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/25</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Guillermo J. Linsao</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>								22c. DATE SIGNED April 26, 1968			
22d. PHYSICIAN'S NAME (Type) Dr. G. S. Linsao						22e. ADDRESS 7308 Furnace Branch Rd., N.E., Glen Burnie					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		April 27, 1968		Glen Haven Cemetery		Ritchie Hwy., A.A. Co.,		Md.			
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore						25a. REC'D BY REGISTRAR DATE APR 29 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



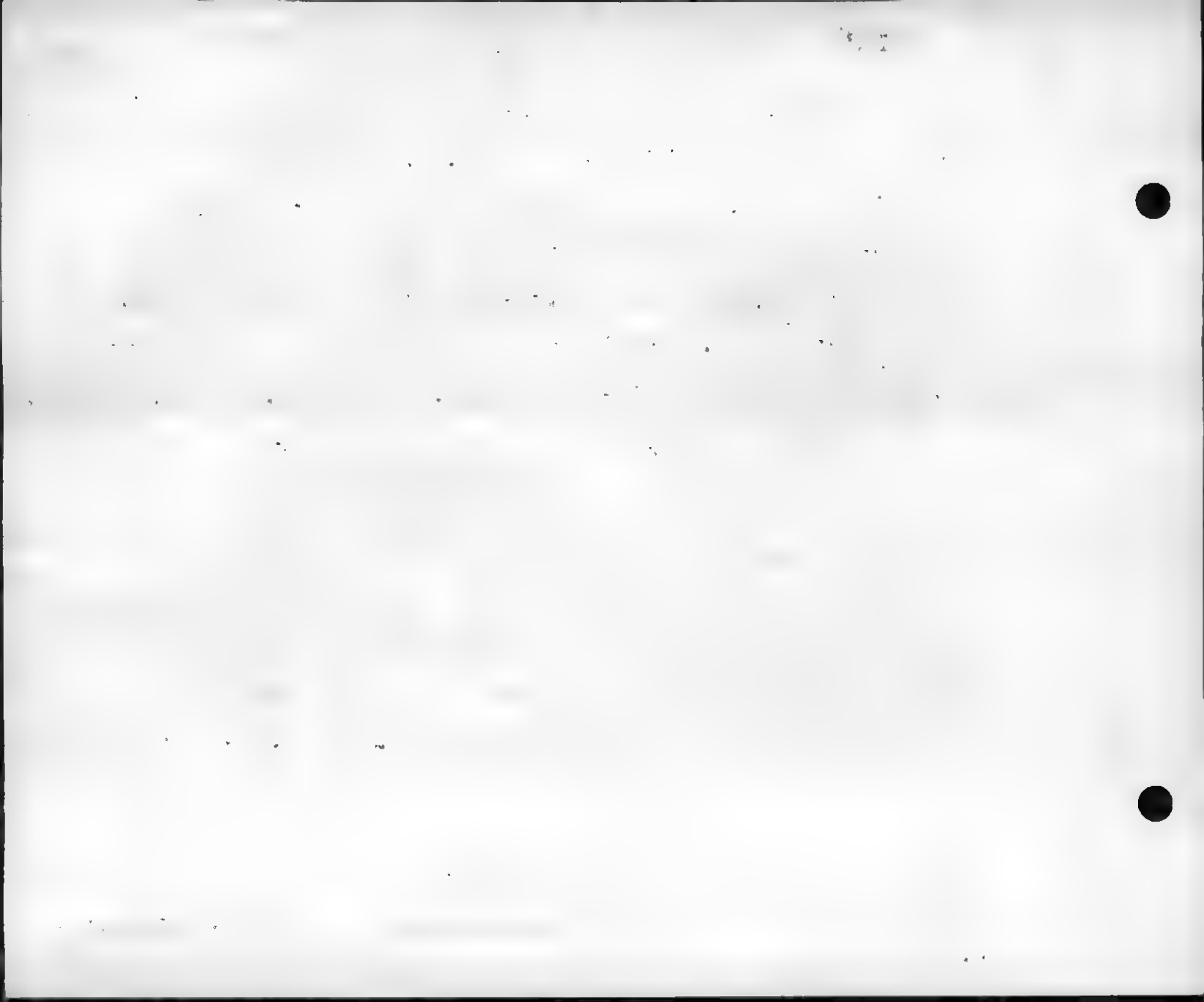
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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last BRADLEY SHIPLEY						2a. DATE OF DEATH 4 Month 25 Day 68 ^{ear}			2b. HOUR 2 P.M.			
3. SEX Male			4. RACE White			5. DATE OF BIRTH Feb. 24, 1884			6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Brooklyn			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 52 1/2 6th Street			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Boiler Maker			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Brooklyn			13d. INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 52 1/2 6th Street	
14. FATHER'S NAME First Middle Last John W. Shipley						15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Shipley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO 218-09-2781			17. INFORMANT Address John R. Shipley, Rt. 2, Sykesville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>												
4109 DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerosis</u>												
(b) _____												
DUE TO, OR AS A CONSEQUENCE OF _____												
(c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
7. _____												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan, 1958, to April 1, 1968, that (I) (we) last saw the deceased alive on April 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Eugene Schnitzer						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) EUGENE SCHNITZER, M.D.						22e. ADDRESS 3904 S. HANOVER ST. Balto. Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/27/1968			23c. NAME OF CEMETERY OR CREMATORY Brandenburg Cemetery			23d. LOCATION (City or Town) (County) (State) Berrett, Carroll, Md.			
24. FUNERAL DIRECTOR C.M. Waltz, Box 241, Sykesville, Md.						25a. REC'D BY REGISTRAR DATE APR 30 1968			25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION



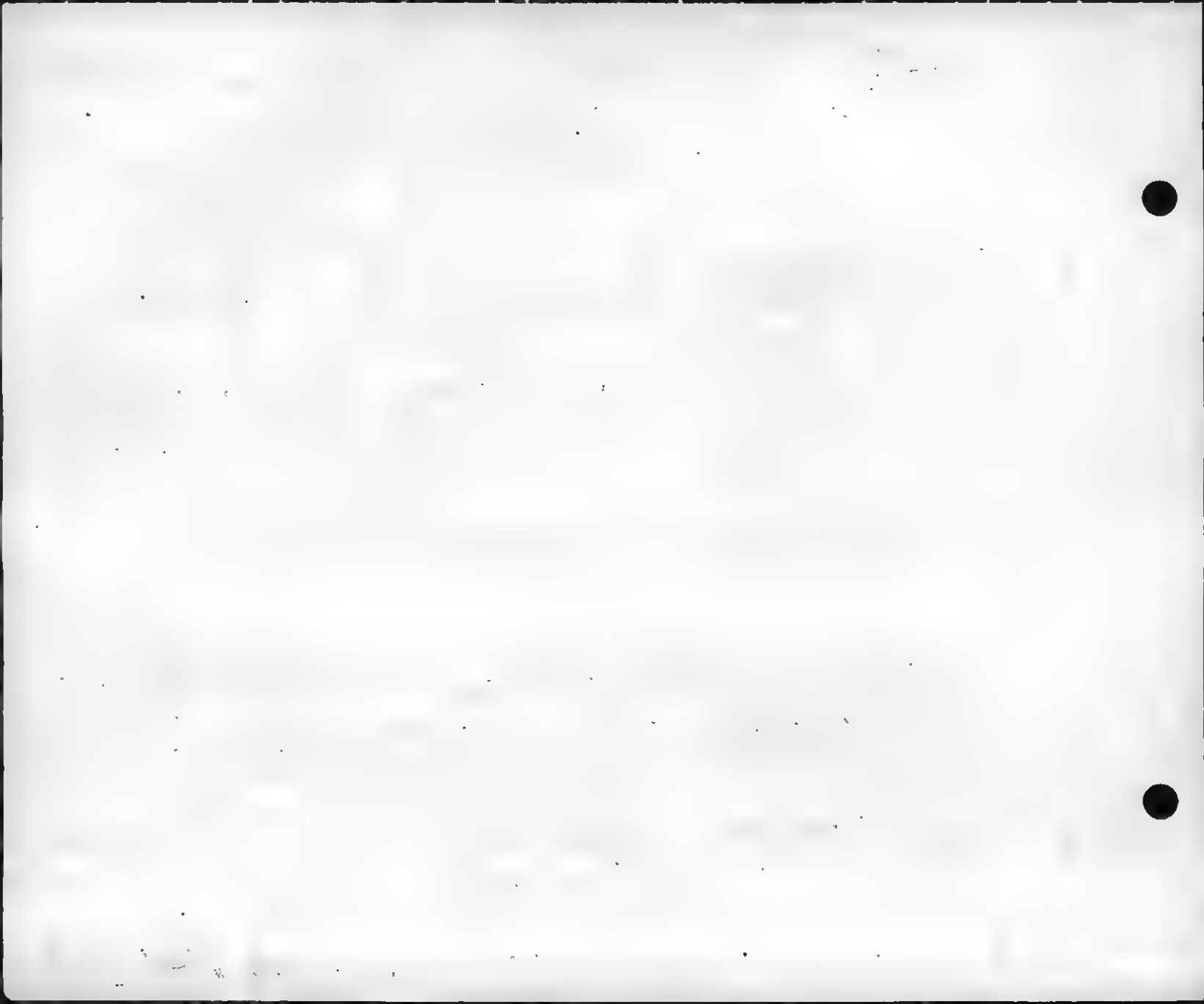
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH MATED		Month	Day	Year	2b HOUR
Joseph H. Sims					<input checked="" type="checkbox"/> 4 12- 1968					P M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	F UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD	
M	W	5-19-26		41 YRS	MONTHS DAYS		HOURS MIN		Month 4 Day 12 Year 1968	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				2d HOUR
Washington D C		U.S.A.				P. D. Co.				P M
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Rivnapolis				DOR - Anne Arundel Gen		Electrician				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER
Md				Pro Geo		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3558 Dean Drive
14. FATHER'S NAME				15 MOTHER'S MAIDEN NAME						
Harry Joseph Thomas				Carrie Wheeler						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		
yes				579 18 9784		Jean H Sims		Hyattsville, Md.		
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u>										<u>10 minutes</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <u>815.7</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>719.4</u>										
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		4/12 1968		Auto accident - struck by car						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No		City or Town		County State		
		Highway		Route 214		PACO		MD		
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b DATE SIGNED		
E. Linhart								7-12-68		
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)		
E. Linhart								PACO		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR RECEPTION		23d LOCATION (City or Town)		(County) (State)		
Burial		Apr 16, 1968		Baltimore National		Baltimore, Md.				
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
F. Gasch's Sons				Hyattsville, Md.		APR 16 1968		Charles Judge		

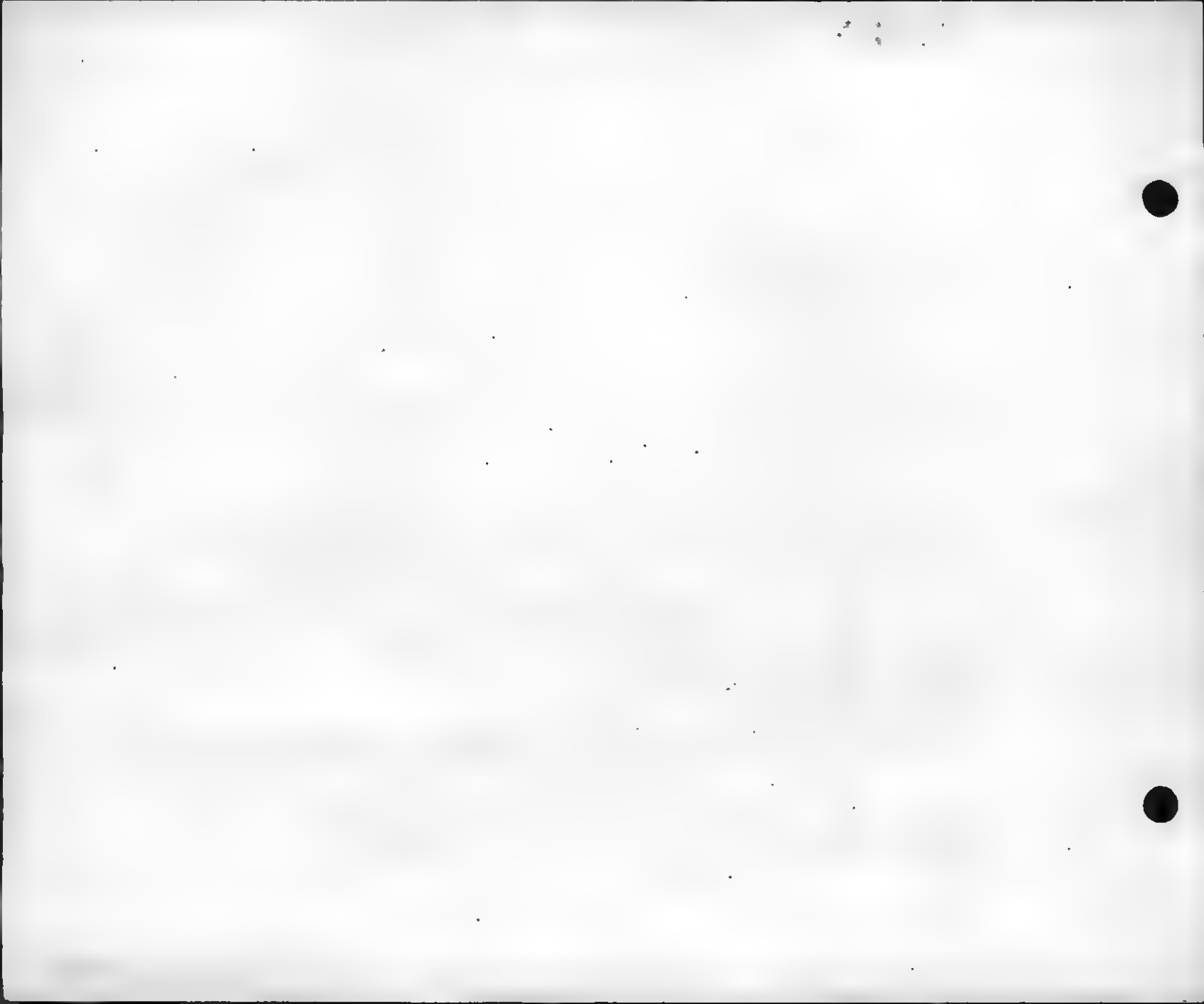


FOR STATE
HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR
Howard				Spencer				Month	Day	Year
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR		8. DATE PRONOUNCED DEAD		2d. HOUR
M	Negro	5-7-22		45 YRS		MONTHS DAYS HOURS MIN		Month	Day	Year
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH				
MD		U.S.A.		NEVER MARRIED		A.A.CO.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Glen Burnie		D.O.A. - North ARUNDEL								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MD		ARCO				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 1 - Box 310A		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
James Spencer		Gertrude Brown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No				Dorinda Spencer - Same						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
		Crushing Injury Chest				Sudden				
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost		(b)		DUE TO, OR AS A CONSEQUENCE OF						
				(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		250								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?						
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
CAUSE OF DEATH:		P.M. 4-15 1968		Caught between Wheel & Cylinder of Truck						
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
		Highway						ARCO		MD
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b. DATE SIGNED
ACTUAL SIGNATURE		E. Linhardt		M.D.						4-15-68
EXAMINER'S NAME (Type)		E. Linhardt		ADDRESS (Street, city, town, or county)						ARCO
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		County		State
Burial		4/19/68		Baltimore National		Baltimore		ARCO		MD
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE				
J. L. Burrows		108 W. Priddyman		DATE APR 18 1968		J. Charles Judge				



1

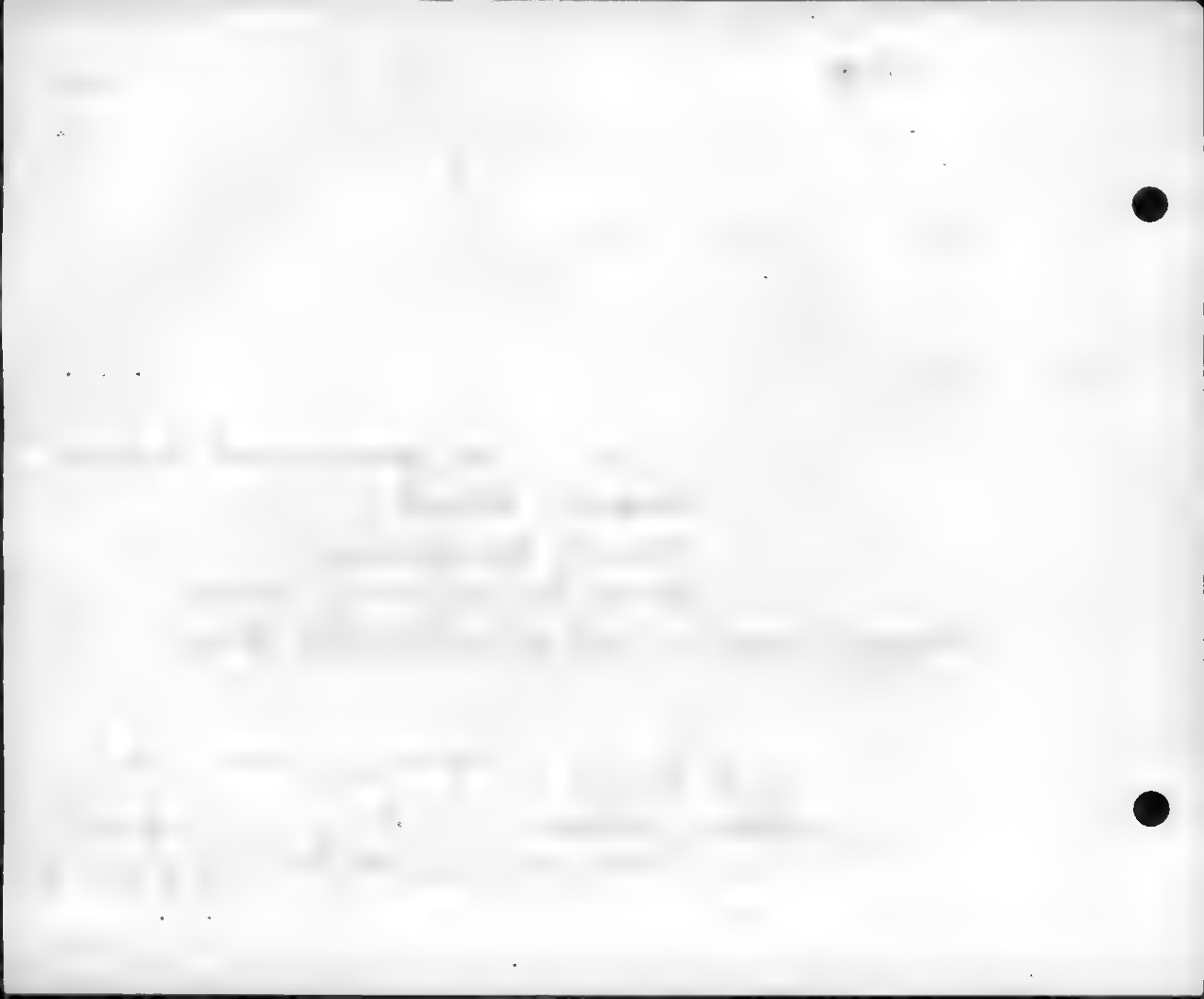
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if instit. on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREEN BURNIE, MD.</u>		c. LENGTH OF STAY IN IT <u>1 MONTH</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>NORTH ARUNDEL CONV CENTER</u>		d. STREET ADDRESS <u>RT 2 BOX 276, Poplar Ridge</u>	
3 NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>STRUENE</u> Last <u>STRUENE</u>		4 DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1968</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 28, 1888</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>August Goltz</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Masureck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Pl's Daughter and Husband</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Generalized Cardiovascular sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>4-5-68</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic congestive heart failure & Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY: Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED: While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-5-1968</u> to <u>4-9-1968</u> , that (I) (we) last saw the deceased alive on <u>4-9-1968</u> , and that death occurred at <u>11:51 P.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Orlando C. Ramos M.D.</u>		22b. DATE SIGNED <u>4-10-68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Orlando C. Ramos M.D.</u>		22d. ADDRESS <u>Arundel Medical Group Ritchie Highway</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/13/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>McLully F.H.</u> ADDRESS <u>237 Patapsco Ave. Balto. Md. 21225</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>APR 15 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE HEALTH DEPT

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) Francis		First WM		M. date TANGEMAN		Lost		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 4 8 68		2b. HOUR 10 P M	
3 SEX M	4 RACE W	5 DATE OF BIRTH 3-23-1926		6 AGE (in years last birthday) 42 YRS	7 UNDER 1 YEAR MONTHS	8 UNDER 24 HRS DAYS	9 UNDER 24 HRS HOURS	10 UNDER 24 HRS MIN	2c. DATE PRONOUNCED DEAD Month 4 Day 8 Year 1968		2d. HOUR 10 P M
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CIT ZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A.CO.				Md	
10 CITY OR TOWN OF DEATH Arnold		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) DDH - Anne Arundel Co		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CIVIL SERVICE		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm'ssion) STATE MD		13b. COUNTY AACO		13c. CITY OR TOWN ARNOLD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RL2-124128			
14 FATHER'S NAME First William		Middle G. TANGEMAN		Lost		15 MOTHER'S MAIDEN NAME First ANNA		Middle BUDDENDECK		Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO DDH		17. INFORMANT JULIA TANGEMAN		ADDRESS #13E					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cushing Monoxide DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 473.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE E. Linhardt		EXAMINER'S NAME (Type) E. Linhardt		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/>	
						ADDRESS (Street, city, town, or county) AACO		22b. DATE SIGNED 4-8-68			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 4-9-68		23c. NAME OF CEMETERY OR CREMATORY ET. LINCOLN		23d. LOCATION (City or Town) BLADENSBURG		(County) MD.		(State)	
24. FUNERAL DIRECTOR John M. L. Loxton		ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR APR 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Coel Armit Thomas			2a DATE KNOWN OF DEATH Month 4 Day 13 Year 1968 2b HOUR 12:30 AM		
3 SEX M	4 RACE W	5 DATE OF BIRTH July 9, 1953	6 AGE (in years) 14 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0
7a BIRTHPLACE (State or foreign country) Penna.		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Annapolis		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bay Ridge Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Student	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MD		13b COUNTY aa		13c CITY OR TOWN Annapolis	
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Box 98 Rt #3 Land End			
14 FATHER'S NAME First Perry Middle C Last Thomas Jr			15 MOTHER'S MAIDEN NAME First Joan Middle Seydel Last Seydel		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS Mr. Perry C. Thomas, Jr. (Same)	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cranio Cerebral Injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 4.13.1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) pedestrian struck by car	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f LOCATION Street or R.F.D. No Bay Ridge Rd City or Town Annapolis County aa State MD	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 4.14.68	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSISTANT MED. CA. EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ADDRESS (Street, city, town, or county)					
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 4/19/68.		23c NAME OF CEMETERY OR CREMATORY Homewood Cemetery	
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		23d LOCATION (City or Town) Pittsburgh, Pa. (County) (State)	
25a REC'D BY REGISTRAR APR 15 1968		25b REGISTRAR'S SIGNATURE John J. Judge			



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VR 116 (4)
30M 11-1-68

MD 158
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <u>First</u> <u>1300</u> <u>Middle</u> <u>Turner</u> <u>Last</u> <u>TURNER</u>			2a. DATE OF DEATH <u>Month</u> <u>April</u> <u>Day</u> <u>14</u> <u>Year</u> <u>1968</u>			2b. HOUR <u>P.</u> <u>1:55</u>	
3 SEX <u>Female</u>		4 RACE <u>White</u>		5. DATE OF BIRTH <u>4/14/1915</u>		6 AGE (In years last birthday) <u>YRS.</u> <u>53</u>	
7a BIRTHPLACE (State or foreign country) <u>Ind.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Anne Arundel</u> Md	
10 CITY OR TOWN OF DEATH <u>Annapolis</u>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>U.C. General</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Teacher</u>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u>		13b COUNTY <u>Anne Arundel</u>		13c CITY OR TOWN <u>Annapolis</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER		14 FATHER'S NAME <u>First</u> <u>Joseph</u> <u>Middle</u> <u>Turner</u> <u>Last</u>		15. MOTHER'S MAIDEN NAME <u>First</u> <u>Janice</u> <u>Middle</u> <u>Harris</u> <u>Last</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT <u>Joseph Turner - Spouse</u>		Address <u>1300 ...</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7762 Cardio-respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF <u></u> (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>773</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF N.J.R.Y. HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>April 14</u> , 19 <u>68</u> , to <u>April 14</u> , 19 <u>68</u> ; that (I) (we) last saw the deceased alive on <u>April 14</u> , 19 <u>68</u> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Francis M. Kopack M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c DATE SIGNED <u>April 16, 68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Francis M. Kopack, M.D.</u>				22e ADDRESS <u>1411 Forest Drive, Annapolis, Md.</u>			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE <u>April 15</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Annapolis Md.</u>	
24 FUNERAL DIRECTOR <u>William ...</u> ADDRESS <u>...</u>				25a REC'D BY REGISTRAR DATE <u>APR 18 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



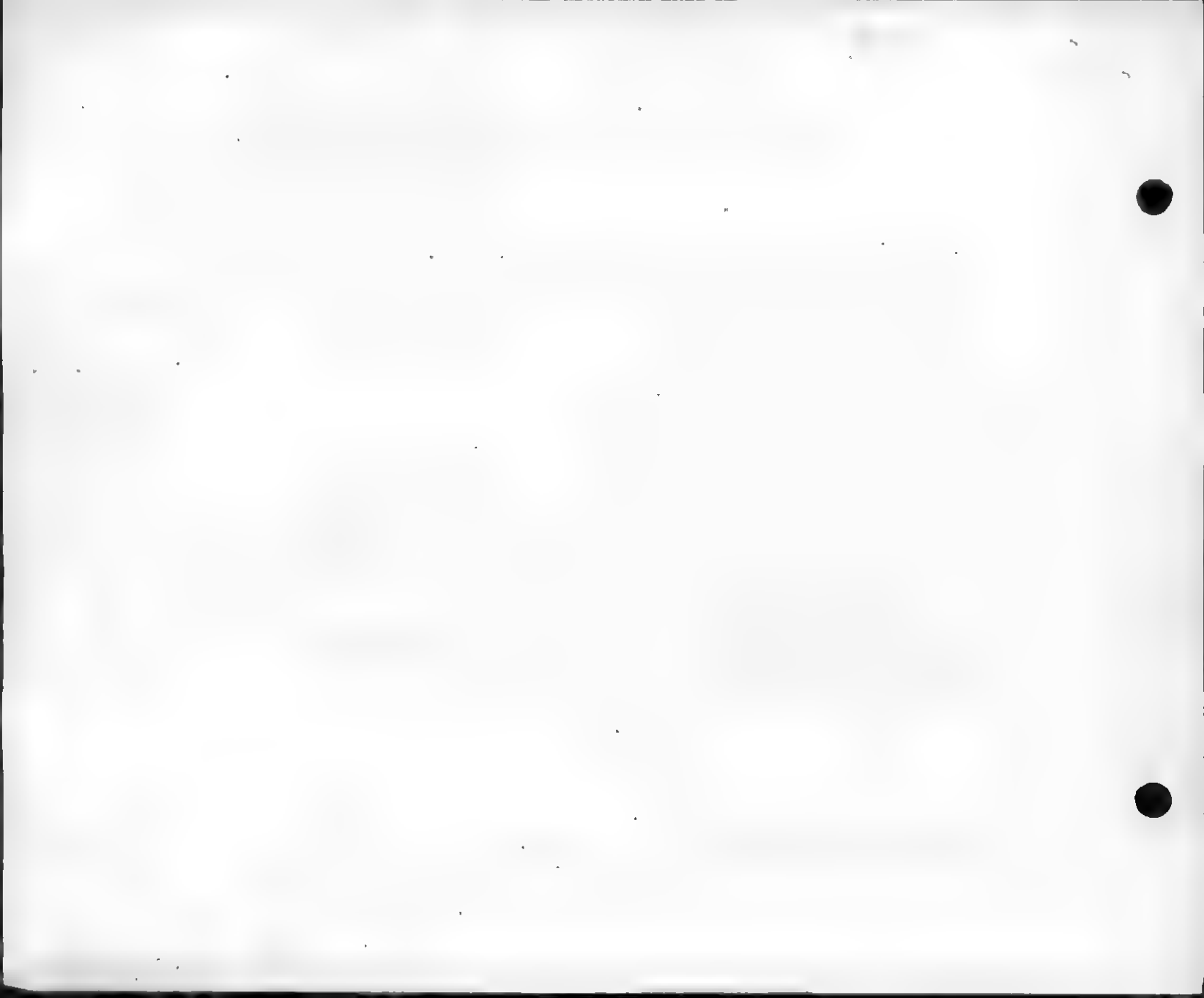
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
DAVID		S.	VAN SCHAICK		MAY 4 27 1968		4	27	1968	P M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (n years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		Month	Day
Male	Cauc.	Mar. 24, 1908		60 YRS	MONTHS	DAYS	4 Day 27 Year 68		4	P M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH				
New York		U. S.				Anne Arundel Md				
8 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Annapolis			Anne Arundel Gen. Hosp.							
13a USUAL RESIDENCE (Where deceased lived if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Maryland		Anne Arundel		Edgewater		YES <input type="checkbox"/> NO <input type="checkbox"/>		Box 395 Beach Drive		
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME						
William Van Schaick				Dorothy (Unknown)						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS				
No		713-14-1029		Daug. Jeanne Irving		Utica, N. Y. XXX				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Disease</u>										<u>Prescribed</u>
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										
(b) <u>Prescribed</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
44										
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b DATE SIGNED		
<u>E. Linhardt</u>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		5/27/68		
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town or county)								
E. Linhardt										
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Cremation		4-29-68		Cedar Hill Crematory		Suitland, Maryland				
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REG STRAR		25b REG STRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland						MAY 3 1968		<u>Charles Judge</u>		



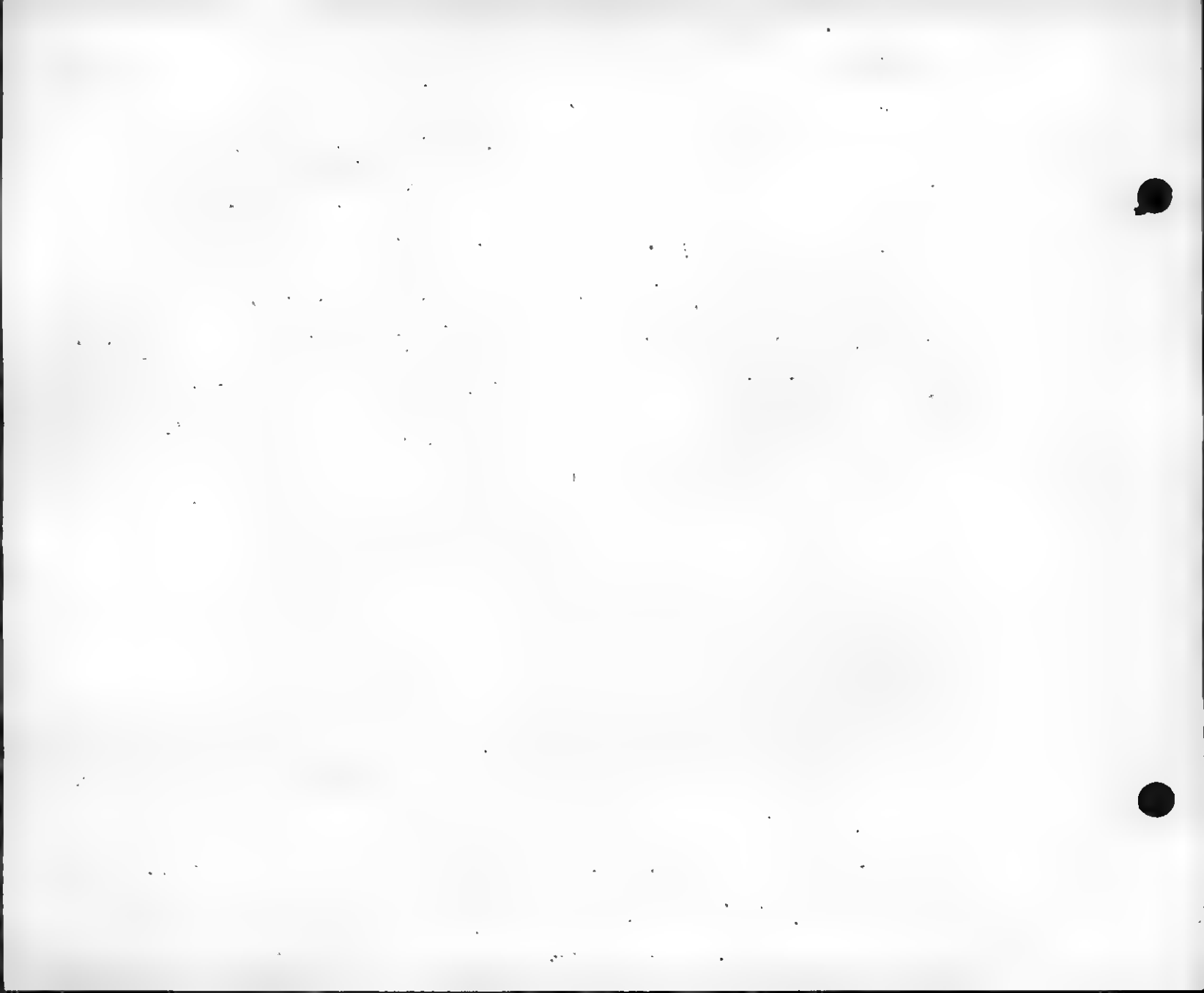
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon paper, page 3, and attach it to the certificate. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 4, and attach it to the certificate. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) WILLIAM H. WEAVER JR.		First Middle Last		2a DATE OF DEATH Month 4 Day 29 Year 68		2b HOUR 3 AM	
3 SEX M		4 RACE W		5. DATE OF BIRTH 6-28-1897		6 AGE (In years last birthday) 70 YRS	
7a BIRTHPLACE (State or foreign country) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.	
10 CITY OR TOWN OF DEATH Annapolis		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 150 GLEN AVE		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CIVIL SERVICE		12b KIND OF BUSINESS OR INDUSTRY Ret.	
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD.		13b. COUNTY A.A.		13c INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 15 N GLEN AVE.	
14 FATHER'S NAME William H. WEAVER SR.		First Middle Last		15 MOTHER'S MAIDEN NAME CAROLINE GESSEH		First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give branch and dates of service) YES WWI-II		16b. SOCIAL SECURITY NO.		17. INFORMANT ELEONORE M. WEAVER #13		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute dilatation of the heart +109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Thrombosis (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4/1/68							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/68 , 19 68 , to 4/29/68 , that (I) (we) last saw the deceased alive on 4/29/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Albert L. Anderson MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/29/68	
22d. PHYSICIAN'S NAME (Type) ALBERT L. ANDERSON		22e. ADDRESS Southgate Ave Annapolis MD.					
23a. BURIAL, CREMATION, REMOVAL Cemetery		23b. DATE 5-2-68		23c. NAME OF CEMETERY OR CREMATORY CEDAR Bluff		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. MD.	
24. FUNERAL DIRECTOR John M. Lytle & Sons Annapolis, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 01 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

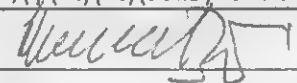




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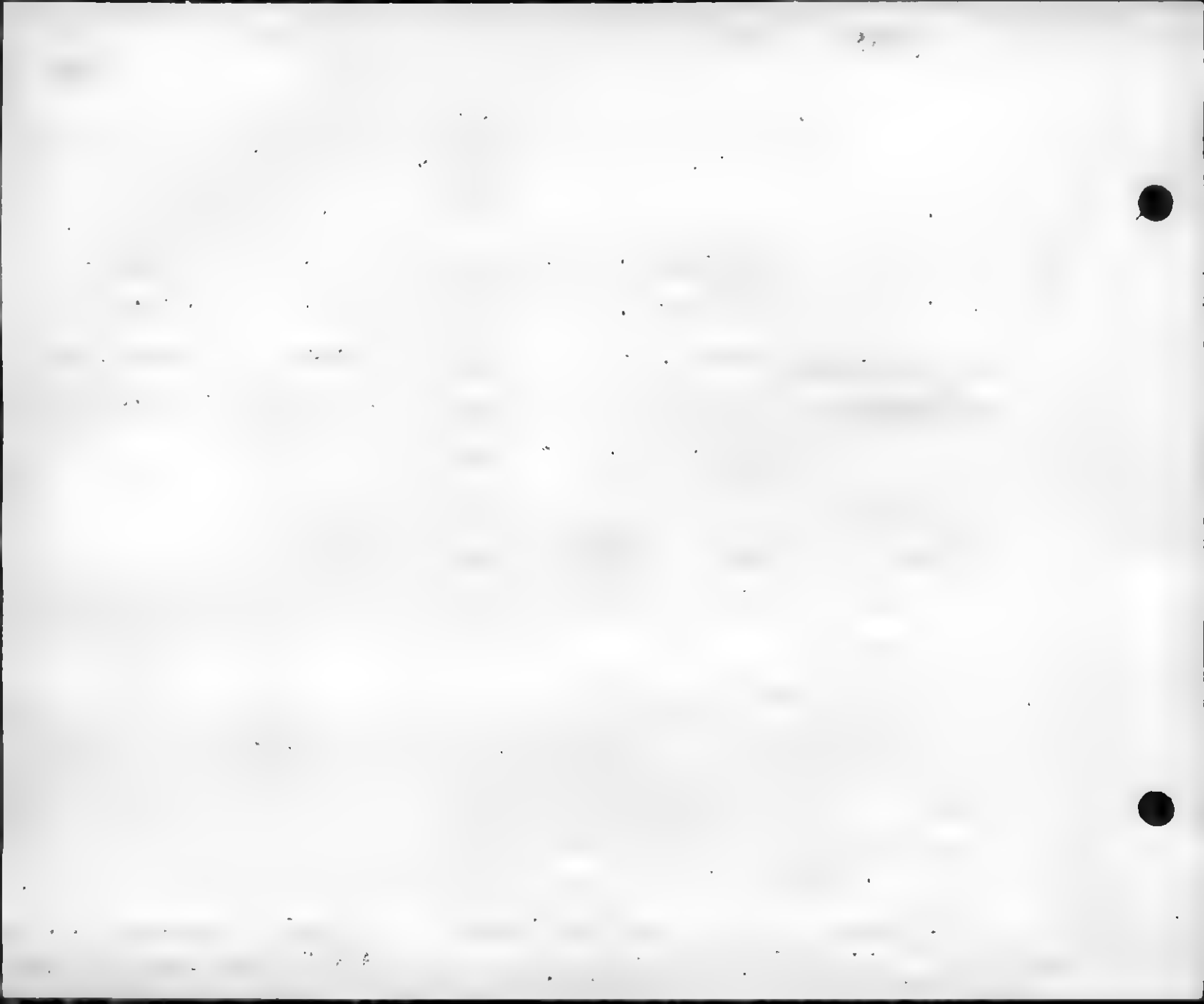
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VR ATS (4)
30M REV 1/68

MD 05155
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Charles H. Wettlin			2a. DATE OF DEATH Month 4 Day 17 Year 68			2b. HOUR 11:10 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9/20/99		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md			
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman		12b. KIND OF BUSINESS OR INDUSTRY real estate			
13a. U.S.A. RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Maryland		13b. COUNTY Baltimore City b		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1846 N. Gay Street	
14. FATHER'S NAME First Middle Last UNKNOWN Charles H. Wettlin			15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN Pettingle						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no UNKNOWN		16b. SOCIAL SECURITY NO. 142-07-7931		17. INFORMANT Hospital Records, Crownsville Maryland		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic alcoholism									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from 4/6, 1968, to 4/17, 1968, that (1) (we) last saw the deceased alive on 4/17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/17/68	
22d. PHYSICIAN'S NAME (Type) L. Benedict, M.D.						22e. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		23b. DATE 4/20/68		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Brielle, Mammoth N.J.			
24. FUNERAL DIRECTOR L. E. Hopping -  Hopping Funeral Home - Annapolis, Md.						25a. RECD BY REGISTRAR DATE APR 22 1968		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

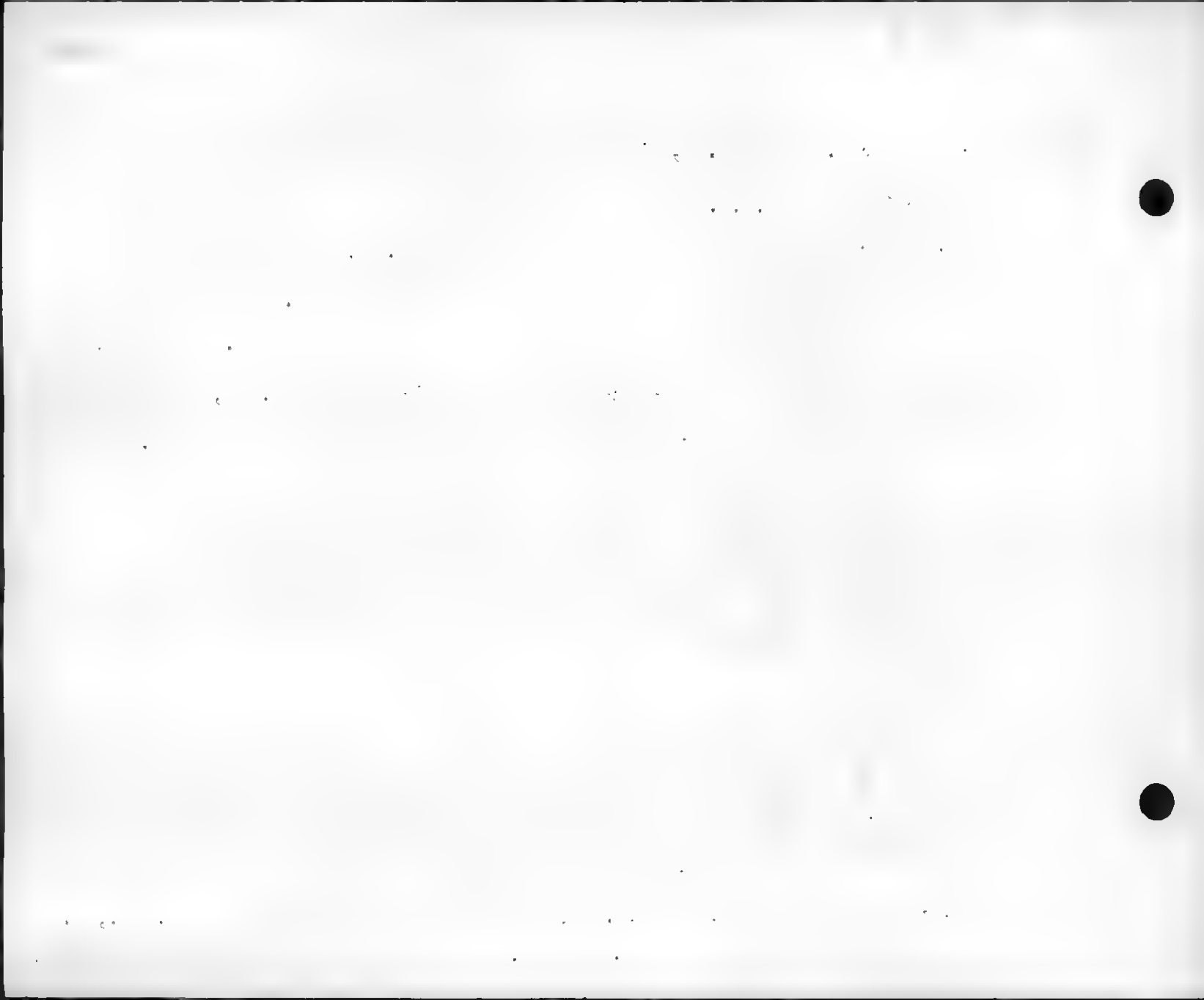


**FOR STATE
HEALTH DEPT.**

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<div>05156</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>												
1. DECEASED NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOJR	
ROYAL HAYS WIGLEY									Month 4 Day 13 Year 1968		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years by birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR		
male	cau.	Sept. 30, 1890	77 YRS					Month 4 Day 13 Year 1968		M		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Maryland			U.S.A.						Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis			Anne Arundel Gen'l			Piano Tuner						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY L.M. 157			
Maryland			Anne Arundel			Annapolis			YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			
George William Wigley			Minnie G. Hays			No			213-2 2-1086			
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF			19. STREET AND NUMBER			20. AUTOPSY?			
Royal Wells Wigley, Rt. #5, Box #128 a			Anteroselecrans Semizal			Rt. #5, Box #128 a			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
450.									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			22. LOCATION			
CAUSE OF DEATH			19						City or Town County State			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No			City or Town County State			
22a. I certify that I took charge of the removals described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. DATE SIGNED			23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			
ACTUAL SIGNATURE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			23e. REC'D BY REGISTRAR			
EXAMINER'S NAME (Type)			23d. LOCATION (City or Town) (County) (State)			23e. REC'D BY REGISTRAR			23f. REGISTRAR'S SIGNATURE			
F. L. W. HARRIS			St. Anne's			Annapolis, A.A. Co., Md.			APR 17 1968			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. DATE			
Hopping Funeral Home			Annapolis, Md.			Charles Judge			APR 17 1968			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		Month		Day	Year	2b. HOUR	
Aurelia Elizabeth WILLIAMS					April 14		1968				12:00 M	
3 SEX	4. RACE	5. DATE OF BIRTH			6 AGE (In years lost birthday)	IF UNDER 1 YEAR		IF UNDER 1 YRS		IF UNDER 1 YRS		
Female	White	2/28/1904			44 YRS	MONTHS		DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Maryland	United States			Anne Arundel								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Cathartsville		St. Joseph's Hosp.			Nurse							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER						
Md.		Calvert	Cathartsville		YES	352 Pearl St.						
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost			
Tricarter					G. Anne							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address						
No		220-4587		Georgia Hopkin		352 Pearl St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis											7 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential Hypertension											2 yrs.	
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
220												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
		HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or RFD No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from 4/7, 1968, to 4/14, 1968, that (I) (we) last saw the deceased alive on 4/14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED				
Richard N. Peeler, MD								4/15/68				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS										
Richard N. Peeler, MD		121 Cathedral St., Annapolis, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		County		State		
Burial		4/15/68		St. John's		Cathartsville		Calvert		Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG STAMP		25b. PREPARED BY						
James A. Jones, Jr. - Annapolis, Md.				APR 16 1968		James A. Jones, Jr.						



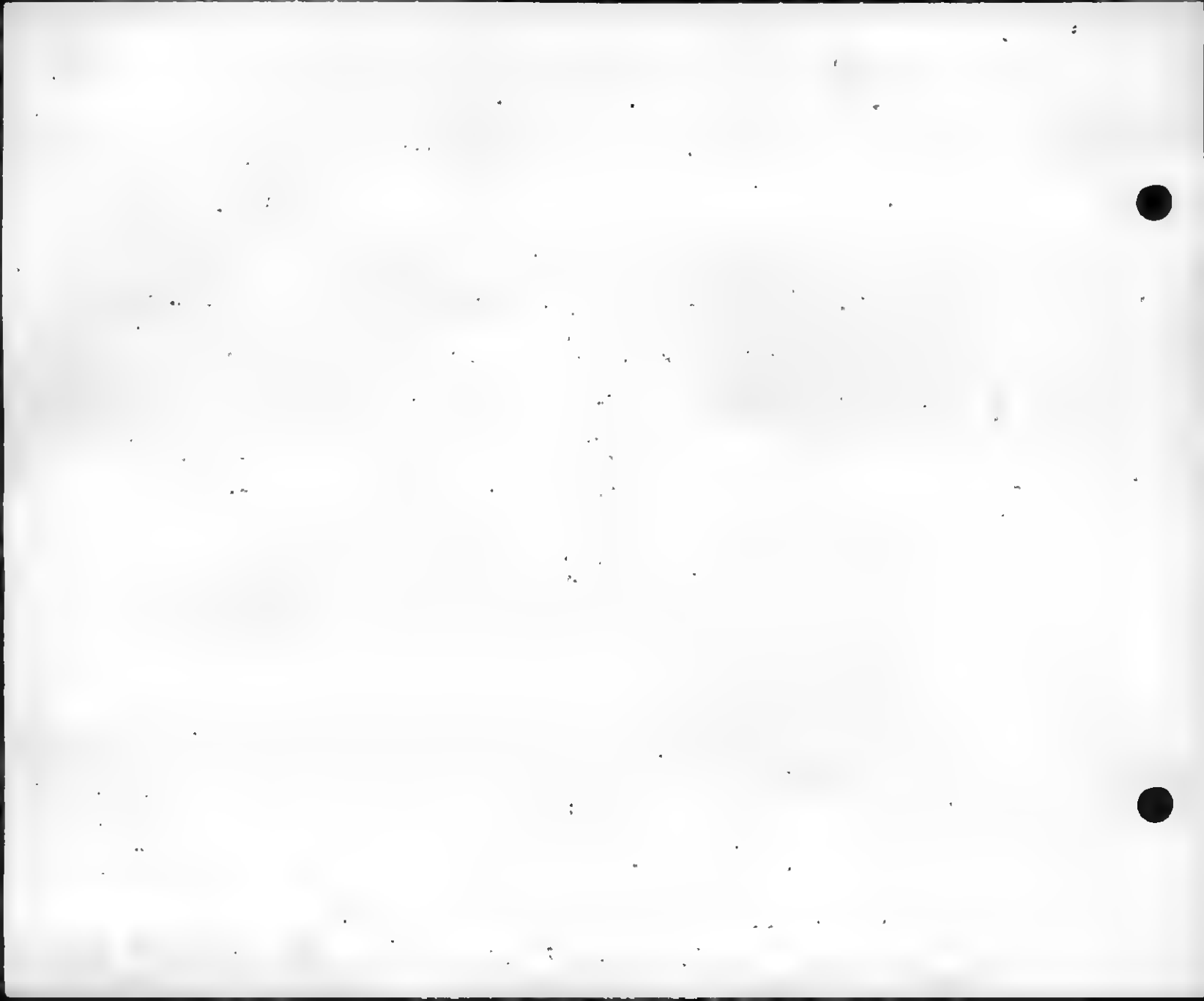
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VR A15 (M)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

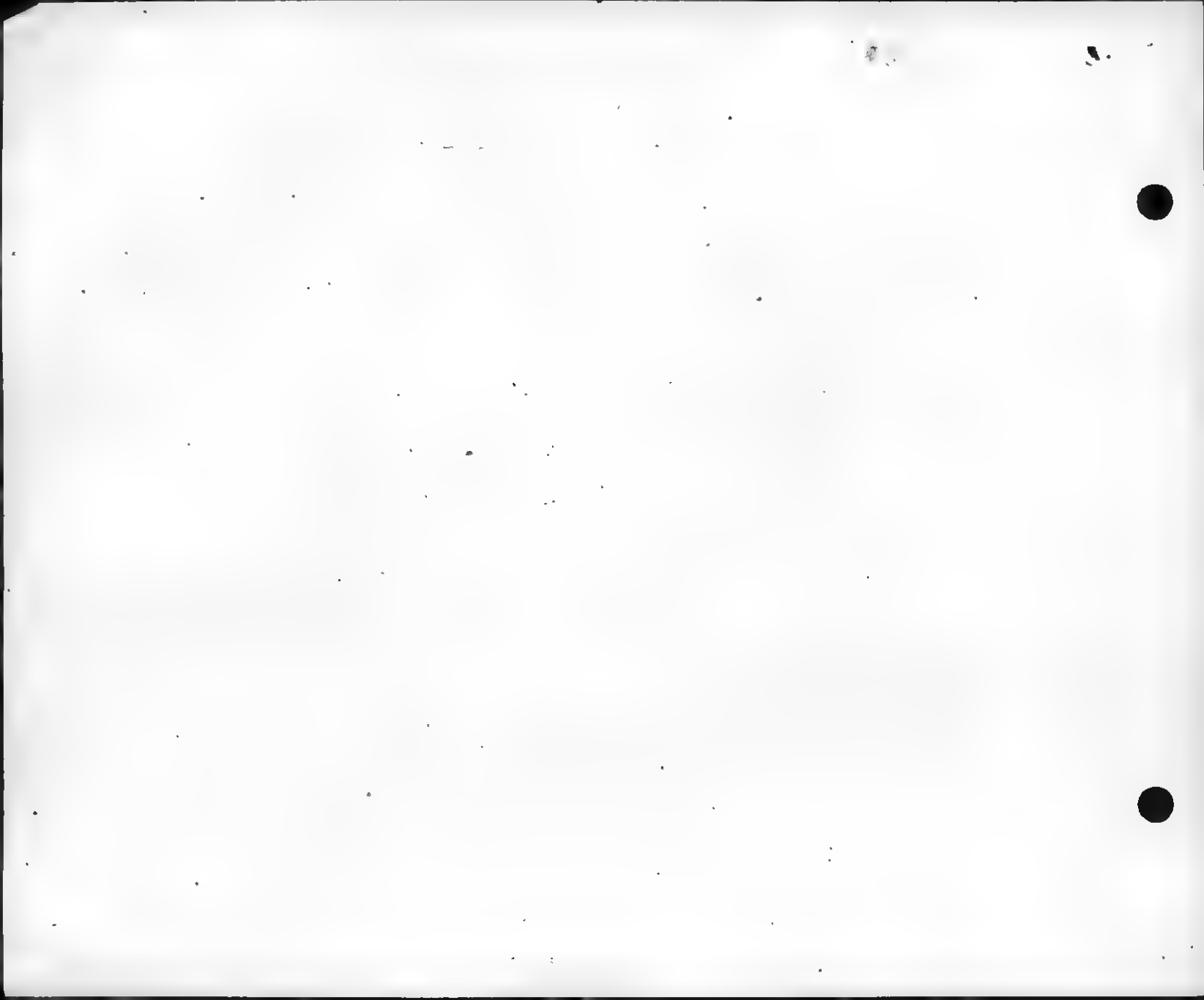
1 DECEASED-NAME (Type or print) First Middle Last Melvin H. Williams			2a DATE OF DEATH Month Day Year 4 15 68			2b HOUR 6 50 P M						
3 SEX Male		4 RACE N.		5. DATE OF BIRTH 8-20-93			6 AGE (In years last birthday) 74 YRS.		7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.						
10 CITY OR TOWN OF DEATH Glen Burnie			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) North Arundel Hosp			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b COUNTY Anne Arundel		13c CITY OR TOWN Glen Burnie		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Box 330 Ordance Road			
14 FATHER'S NAME First Middle Last Williams Henry Williams			15 MOTHER'S MAIDEN NAME First Middle Last Sarah M. Brooks									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes War # 1			16b. SOCIAL SECURITY NO 216-44-3255			17. INFORMANT Address Hospital Records						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis - Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) APHA											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR COMP. BURNING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or RFD No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 4/14/68, 19, to 4/15/68, 19, that (I) (we) last saw the deceased alive on 4/15/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE J. B. Ranning MD			22c. DATE SIGNED 4/15/68			22d. PHYSICIAN'S NAME (Type) J. B. Ranning MD			22e. ADDRESS 3527 Park View Ave. #111, Baltimore 27 325 Hospital Dr. Sen. Anne Arundel			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April-20-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery			23d. LOCATION (City or Town) (County) (State) Brooklyn Md.				
24. FUNERAL DIRECTOR Stinson & Wilsey 1913 W. Belts, Md			25a. RECEIVED BY REGISTRAR DATE APR 22 1968			25b. REGISTRAR'S SIGNATURE J. Charles Juge						



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Max E. Woelfer			2a. DATE OF DEATH 4 Month 19 Day 68 Year			2b. HOUR 3AM M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 2-15-88		6. AGE (In years last birthday) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Ann Arundel Co. Md.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Loudon Park Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Baker		12b. KIND OF BUSINESS OR INDUSTRY Tolson, Bk.			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Ann Arundel		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 186 Burns Crossing Rd.	
14. FATHER'S NAME Max E. Woelfer			15. MOTHER'S MAIDEN NAME (UNKNOWN)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 217-09-3919		17. INFORMANT A. (Elsa F. Woelfer)		Address Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 2837 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myeloid Metaplasia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASHD, Congestive Heart Failure</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4/18/68 to 4/19/68, that (I) (we) last saw the deceased alive on 4/18/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C. Driskan		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/19/68					
22d. PHYSICIAN'S NAME (Type) C. Driskan		22e. ADDRESS 325 Hosp. Drive, G. Burnie, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/23/68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Singer Funeral Home/Glen Burnie, Md. Robert P. Ware				ADDRESS 25a. REC'D BY REGISTRAR DATE APR 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



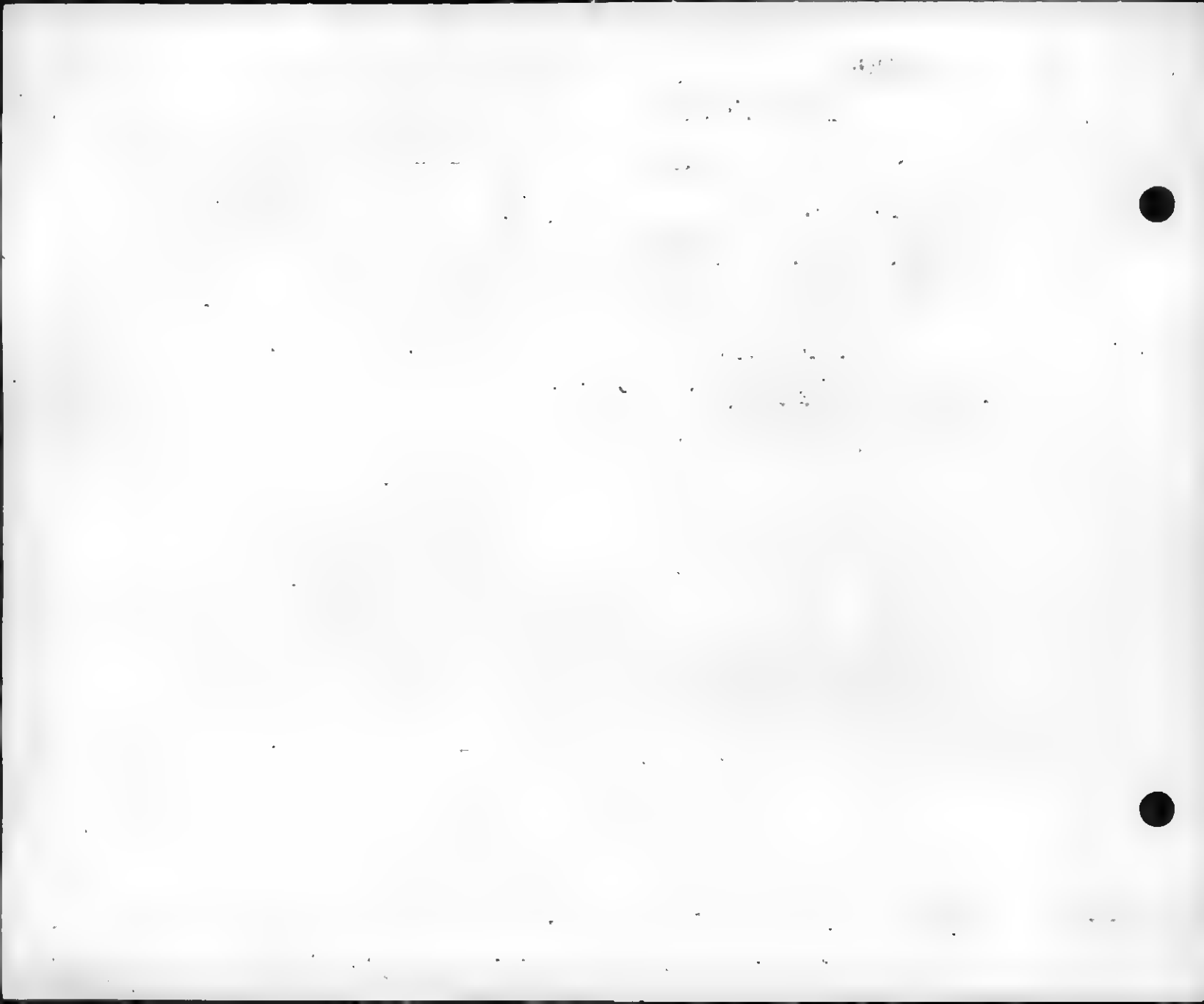
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VR A15 (4)
30M REV 1/68

MD 25180
MAY 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Thomas C. Wood SR.		First LAGETT		Middle SR.		Last		2a. DATE OF DEATH Month 4 Day 5 Year 1968		2b. HOUR 1:10M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 11-11-70		6 AGE (In years last birthday) 97 YRS.		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Lothian, Md.		7b CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md					
10 CITY OR TOWN OF DEATH Annapolis, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bay Manor Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CLERK		12b. KIND OF BUSINESS OR INDUSTRY CLERK					
13a USLA. RES DENCE (Where deceased lived, if institution. Residence before admission) STATE MD		13b. COUNTY AA		13c CITY OR TOWN Annapolis		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER None			
14. FATHER'S NAME First Middle Last Dr. Edgar Wade Wood				15. MOTHER'S MAIDEN NAME First Middle Last SARA HOUSES Clagett							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give branch and date of service)		16b. SOCIAL SECURITY NO. 14-54-2437		17 INFORMANT Address None							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 486X IMMEDIATE CAUSE (a) pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic cardiovascular disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11-29-67 , 19____, to 3-5-68 , 19____, that (I) (we) last saw the deceased alive on April 2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Am Smith				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED April 6, 1968					
22d. PHYSICIAN'S NAME (Type)				22e ADDRESS							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-10-68		23c NAME OF CEMETERY OR CREMATORY Forest Hill		23d. LOCATION (City or Town) (County) (State) Annapolis MD					
24. FUNERAL DIRECTOR Charles Judge				ADDRESS 1111 N. ...		25a. REC'D BY REGISTRAR DATE APR 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Chester R. Young		2a. DATE OF DEATH 4 Month 23 Day 68 Year		2b. HOUR 4A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9-20-1894		6. AGE (In years last birthday) 73 YRS.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Ann Arundel Md.
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Rt. Store Man, Conch
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY A.A. Co.	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First John Middle T Last Young		15. MOTHER'S MAIDEN NAME First Estelle Middle Masimer Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 21705 3060		17. INFORMANT Mr. Chester Young Jr. Severna Park, Md Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4129 IMMEDIATE CAUSE (a) ASHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Gastric Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 4/22/1968 , to 4/23/1968 , that (I) (we) last saw the deceased alive on 4/22/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE William J. Masimer		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/23/68
22d. PHYSICIAN'S NAME (Type) Dr. J. H. Masimer		22e. ADDRESS 10 A H. Glen Burnie Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/25/68	23c. NAME OF CEMETERY OR CREMATORY Meadowridge	23d. LOCATION (City or Town) (County) (State) Dorsey Howard, Md	
24. FUNERAL DIRECTOR BARRANCE Funeral Home, Inc		ADDRESS Severna Park, Md		25a. REC'D BY REGISTRAR APR 26 1968 DATE
				25b. REGISTRAR'S SIGNATURE Charles Jones

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[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) George		First H.		Middle Zobel		Last		2a. DATE OF DEATH Month April Day 17 Year 68			2b. HOUR 2:55 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10 - 15 - 87			6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.						
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Transit Co.			12b. KIND OF BUSINESS OR INDUSTRY East City				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 728 Griffith Rd. 21061				
14. FATHER'S NAME First Andrew A. Middle Zobel Last		15. MOTHER'S MAIDEN NAME First Frances Middle Budger Last										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 213-10-3016		17. INFORMANT Address (Glen Burnie) Mrs. Laverne Smithell - 728 Griffith Rd								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASHD. DUE TO, OR AS A CONSEQUENCE OF (c) (d) 											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200 Aneurysm of Abdominal Aorta. Aneurysm												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 4/11/1968 , to 4/17/1968 , that (I) (we) lost the deceased alive on 4/17/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE C. Dorkan		DEGREE 		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/17/68		
22d. PHYSICIAN'S NAME (Type) C. Dorkan		22e. ADDRESS 325 Hosp. Drive, G. Burnie, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/20/1968		23c. NAME OF CEMETERY OR CREMATORY Truster Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md.						
24. FUNERAL DIRECTOR John J. Cowan & Son Inc.		ADDRESS 901 Hollins St. 23 Md.		25a. REC'D BY REGISTRAR 		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE APR 19 1968				

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